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HEALTH CARE REFORM (Part 6)

HEARINGS BEFORE THE SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT OF THE COMMITTEE ON ENERGY AND COMMERCE HOUSE OF REPRESENTATIVES ONE HUNDRED THIRD CONGRESS FIRST SESSION

NOVEMBER 22, 1993—FINANCING
DECEMBER 8, 1993—BENEFITS AND COVERAGE
DECEMBER 9, 1993—HEALTH PLANS, RISK ADJUSTMENT, AND
CORPORATE ALLIANCES

Serial No. 103-91

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HEALTH CARE REFORM Financing

MONDAY, NOVEMBER 22, 1993

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
Washington, DC.

The subcommittee met, pursuant to notice, at 11 a.m., in room 2123, Rayburn House Office Building, Hon. Henry A. Waxman (chairman) presiding.

Mr. WAXMAN. The meeting of the subcommittee will come to order.

Two days ago the Health Security Act, H.R. 3600, was introduced in the House by Mr. Gephardt. I am cosponsoring this legislation because it is the first Presidential initiative since 1979 to extend universal coverage for comprehensive health benefits to all Americans. Crucial to the ability of H.R. 3600 to achieve universal coverage is the adequacy of financing.

According to administration estimates, the President's plan includes \$352 billion in new Federal spending between now and the year 2000, half of which is for subsidies for employers, low-income families and early retirees. The plan contains \$408 billion in funding, nearly half of which—\$189 billion—comes from reductions in Federal Medicare and Medicaid spending. Again by the administration's calculation, this leaves \$56 billion remaining for Federal deficit reduction.

Of course the Federal Government is not the only party to the financing of this plan. Virtually all Americans will share in the costs through deductibles and coinsurance requirements built into the benefit design. Employers will contribute 80 percent of the premiums of their workers, up to 7.9 percent of payroll. Workers who are not eligible for low-income subsidies will pay the remainder of the premium of the plan they select, up to 3.9 percent of their incomes.

The States will make payments of approximately \$75 billion between now and the year 2000 to the Regional Alliances in the form of maintenance of effort payments on behalf of former Medicaid beneficiaries. In addition, States will be paying their share of the costs of the Medicaid population receiving cash assistance.

There has been criticism of the administration's proposals for financing universal coverage. One of our witnesses today who served in a Republican administration that did not ask the Congress to enact universal coverage has announced it as "tooth fairy" financing. The purpose of our hearing this morning is to give the admin-

istration an opportunity to explain its estimates and the assumptions that underlie them.

This is not the last time the subcommittee will hear testimony on the issue of financing the President's plan. We anticipate that in late January or early February Dr. Reischauer, the Director of the Congressional Budget Office will present CBO's independent analysis of the President's plan.

We will, of course, be bound by that analysis in our consideration of H.R. 3600 when we take up the bill early in the next session. Until then, however, today's testimony will guide our thinking about the legislation.

Before calling on our witnesses, I want to recognize subcommittee members for opening statements and I will recognize Mr. McMillan first.

Mr. McMILLAN. Thank you, Mr. Chairman.

I am glad we have one more opportunity to discuss financing of the Health Security Act. I would certainly be happier, of course, if the administration had chosen to give this committee access to their full financial data and assumptions a long time ago because I think that is absolutely essential to an intelligent debate on the issue.

I understand that the final bill has been introduced which was some 1,380 pages that the analysis of the difference between the new bill and the old original bill is over 60 pages long. So we obviously don't have full information and that makes it rather difficult. I have brought up at earlier meetings with the Budget Committee and in this committee that I am very interested in getting at these details.

You have been cooperative and Mr. Thorpe has particularly in providing aggregate numbers on funds flow but this subcommittee still does not have details on the subsidy levels for small business, low-wage earners, the true cost of picking up 80 percent of early retiree benefits, et cetera.

Nor does it deal with disproportionate share payments to hospitals or make a determination whether they will be preserved as a distortion in the apportionment to States. Nor does it show whether Medicaid payments for nursing care are transferred to Medicare accounts or included in the regional alliances.

While the administration has provided the overall funds flow information, this has not been broken down into budget accounts so that this legislation can be debated intelligently.

We have to debate on the Floor about the rescission package and the absence of accurate data on the administration proposal is confusing that debate enormously, and frankly we are being misinformed about many aspects of it. These numbers are vitally important to the ability of the committees of jurisdiction to come to grips with this issue.

I find it interesting that the administration criticizes the bipartisan bill that will be on the Floor today for using up savings. However, if we really got behind this, I think we would find that most of the savings proposed in the Penny-Kasich bill are the same savings that the administration proposes to be used within the months or as soon as we adopt that bill.

Surely the administration knows that all of these funds are fungible. In fact, your whole health care plan is based on the notion that these funds are fungible because basically you will be reallocating from one program into another program. The Health Security Act is, as best I can determine, despite the criticism, has within it \$26 billion in savings in the same programs that the Penny-Kasich Act will ask that Congress consider today. Contrary to the assertions, Penny-Kasich does not use up those savings. If they are named and enacted in the rescission today, it will advance them by a matter of months between the time of this rescission package and adoption of the Clinton health care plan if and when the \$58 billion in deficit reduction that are proposed in your health care plan will not be taken away. It simply is advanced by a matter of months.

I think we would have a lot more intelligent debate on issue that we will face today and as we face it later if in fact the committees of jurisdiction are given access to what Secretary Bentsen described as the "finest actuaries in the United States" and other experts that have examined this plan. The American people are entitled to it and I think the Members of Congress are.

Thank you and I yield back the balance of my time.

Mr. WAXMAN. Thank you, Mr. McMillan.

Mr. Wyden.

Mr. WYDEN. Thank you, Mr. Chairman.

I commend you for holding what I think is an extraordinarily important hearing. I think that most Americans come to this subject and look at the proposition that we are spending close to \$1 trillion now each year on health care. With 257 million Americans, you could give every person in this country \$3,300 and in effect say "Here. Go out and make the health care system work."

That is how the system works or how it can work, but I think it goes to the heart of what people are concerned about, and that is that they are not fools on the financing issue. Americans know that some people and businesses are going to pay more than they do today and others are going to pay less. It seems to me that if the administration and the Congress don't tell the American people who is going to take a hit and who is getting a break, people will suspect that no news is bad news and particularly they are going to see that in a very personal way.

What I am interested in hearing from Dr. Rivlin, from the administration today more than anything else, is information about who pays how much today and how that would be changed under the administration's plan. I think that goes right to the heart of what the public wants to hear.

It also means acknowledging that the keystone of the President's proposal is essentially the employer mandates, the employer mandate is the way that millions of individuals and businesses are going to be pitching in to finance health reform and I think we need to know who under the mandates is going to be spending a lot more and who is likely to be spending less.

Mr. Chairman, I think this is a very important hearing, an excellent way to end the round of hearings that we have held over the last week, and I look forward to hearing from Dr. Rivlin and our witnesses.

Mr. WAXMAN. Thank you Mr. Wyden.

Mr. Bliley.

Mr. BLILEY. Thank you, Mr. Chairman.

Mr. Chairman, today's hearing marks this committee's 20th hearing on health care reform since the First Lady's appearance before us on September 28th. I would first like to personally thank you for the cooperation you have extended to the Minority in putting these hearings together. It is clear that the administration, providers, insurers, and the public have been fairly represented at these hearings.

The committee's conduct and tone have been thoughtful and analytical, rather than acrimonious and ideological. I believe that this committee's hearings have been the top congressional forum, where both the press and public have turned for substantive debate of the bill. Mr. Chairman, I want to thank you and your staff.

I would also like to welcome two distinguished guests who are appearing before us today. First I would like to welcome Dr. Alice Rivlin, the Deputy Director of OMB. Dr. Rivlin was the first Director of the CBO and has made many contributions to our understanding of both the Federal budget and the budget deficit.

I would also like to welcome Dr. Gail Wilensky who served with distinction in the Bush administration as HCFA Administrator and as Special Assistant to the President for Health Care. Dr. Wilensky has appeared many times before this committee to help guide us through many of the complicated Medicare and Medicaid issues of past budget reconciliations.

Since this is the last committee hearing before the recess, I would like to make some general comments. First, the administration has done both Congress and the public an injustice by its refusal to provide either the legislative language until 2 days ago; or its budgetary, financial, actuarial, and economic assumptions and documentation to the Congress.

Our understanding is that the introduced bill, H.R. 3600, has dozens of substantive changes from the "Draft Health Security Act." It is only fair that the public, physicians, hospitals, insurers, and other interested parties be given another chance to again testify before this committee on the "real bill." I hope we can get a commitment from the chairman that we hold another set of hearings in February so that everyone can testify on the introduced bill, and not a "draft".

It has now been 2 months since Mrs. Clinton promised this committee the budgetary, actuarial and economic documentation for this bill. Congressman McMillan, other members and I have all written numerous letters requesting this information, and so far we have received nothing.

Dr. Rivlin, you are the No. 2 official at OMB. Before you leave today, I am going to ask you for a meeting next week so that you and other interested members of both parties can work out a reasonable schedule for "opening up your books" to the public. Let our Nation's best health care economists, actuaries, and financial experts examine your models, assumptions, and conclusions.

If you don't open your books, the only conclusion that we can draw is that your numbers are phony! This is not a partisan issue. Let me remind you that some of the biggest critics of your numbers have been members of your own party, for example, the gentleman

from California, the Chairman of the Health Subcommittee of the Committee on Ways and Means, Pete Stark.

Now I would like to make some comments concerning the administration's use of the English language, which I am afraid is symptomatic of the underlying logic of the bill. Let us not forget that this is the first bill ever created by the "tollgate process."

First we had the administration characterization of the National Health Board, the body which would control the Nation's \$1 trillion health care system. First, Secretary Shalala testified before us that it was simply a "minor oversight group with some functions," and would probably have just 100 staff members, although its annual budget would be over \$2 billion. Then the HCFA Administrator characterized the board as just a steering committee. This would be like characterizing the House Rules Committee as just a steering committee.

How about the administration's characterization of entitlements? This bill is creating several new entitlements with hundreds of billion dollars of new Federal entitlement spending. First the administration called these entitlement payments subsidies. Now they call them premium discounts. What is next? How about Federal bonus payments to deserving companies and individuals?

Finally, we have the most egregious misuse of the English language, the definition of what is a Federal revenue and expenditure. Put simply, the administration would have the American public believe that a mandatory payroll tax enacted by Congress with Federal penalties should be treated like a private transaction like shopping at K-Mart.

Today's hearing is about financing. As I said at our November 8 hearing on cost containment, this hearing is the flip side of the cost containment hearing. Why? Because the cost containment features of the Clinton plan are also its primary financing mechanism. If the premium cap is removed from this bill, the overall financing of the health care plan would fall apart like a house of cards.

To conclude, I would like to quote from the Chief Actuary of HCFA verifying this very conclusion: "The health care reform plan relies heavily on global budgets enforced by the Federal Government—for example, the actuarially determined premiums for the first year of reform, 1996, are reduced by nearly 25 percent by the global budget, and the associated Federal subsidies are reduced by more than 40 percent—to be that successful in containing costs, the Federal Government would have to be far more resolute than it has been in containing costs in Medicare and Medicaid."

This was quoted from The Actuary dated November 1993.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Bliley.

Mr. Rowland?

Mr. ROWLAND. No.

Mr. WAXMAN. Mr. Kreidler?

Mr. KREIDLER. I will pass.

Mr. WAXMAN. Mr. Brown?

Mr. BROWN. No.

Mr. WAXMAN. Mr. Hastert.

Mr. HASTERT. Quite briefly, Mr. Chairman. It is time that we get the facts and figures. We have talked about this before, a bill that

was supposed to be before the Congress last May 17, I think was the target date. And then the date was rolled to July 4, then to the August recess, then to September, and then October and November and we are still waiting.

The numbers—we have been continually promised that we would see the models, that we would see the numbers, that we would see the schemes that were put together that made this thing possible and made it work. Yet, we have been denied this information, so you can see that you are before a part of a panel this morning that is somewhat frustrated.

We welcome the opportunity for you to come before us and start to lay out details so that we can begin to make sense out of what the White House health care plan is so that we can be responsible to the American people. I appreciate your being here this morning.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Hastert.

Our first witness is Alice Rivlin, Deputy Director of the Office of Management and Budget. She is a nationally recognized economist and has previously served in the Executive Branch as Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services. She is especially well qualified to present the administration's estimates to us this morning since she was the founding director of the Congressional Budget Office, where she served with distinction from 1975 to 1983.

I am pleased to welcome you to the subcommittee. Your appearance here marks the first time since 1981 that any official of the OMB—much less the deputy—has been willing to appear before the subcommittee in a public hearing and defend the administration estimates. I thank you for that.

Without objection, your full statement will be part of the record in its entirety. We would like to ask you to proceed however you wish.

STATEMENT OF ALICE M. RIVLIN, DEPUTY DIRECTOR, OFFICE OF MANAGEMENT AND BUDGET

Ms. RIVLIN. Thank you very much Mr. Chairman. I am delighted to be here. I don't know why there hasn't an OMB deputy director here since 1981, but I can assure you that I am willing to come at any time it would be helpful. OMB, as well as the rest of the administration is very eager to work with this committee to share the information that we have, to explain our bill, and to get your views on how to improve the bill.

This whole enterprise of reforming health care is difficult. It is complicated. We are all in it together, and this hearing I hope will be the first of many hearings and discussions in which we go over the numbers, we explain what we did and you tell us what you think might have been a better way to do it. We need to share the information and the wisdom in this very difficult enterprise.

Let me just summarize my statement very briefly. I will say a word or two about the impact of health care on the economy and then turn to the impact of the Clinton health reform on the Federal budget and how we think that those numbers add up.

Mr. Chairman, we all want a productive high-wage economy in which incomes are rising. This committee has been on the forefront

of pointing out many of the difficulties from an economic point of view with our current health care system.

I think we can all agree that the current health care system threatens the future of the American economy in at least three ways. Health care costs are very high and they are rising rapidly. This amounts to a health care tax essentially on the whole economy to support a relatively inefficient health care system. Health care programs in the government budget has been rising extremely rapidly, adding to the deficit and punishing the economy.

The fact that not everyone has health insurance and that many people are worried about losing their health insurance has led to health care insecurity, to job lock and welfare lock, which also punishes the efforts to get to a high productivity economy.

The market for health care is simply not working as markets ought to work. In this situation, the government could take over and regulate the prices and quantity of care. That is a possibility. It is not the possibility that the Clinton administration chose. We chose the more complicated task of trying to restructure the market for health care to make it work better.

The Health Security Act preserves the employer-based insurance with which most Americans are familiar. It insures universal coverage by mandating a standard benefit package that employers must provide. It makes that package affordable by providing subsidies to firms with low wage workers and to low-income individuals. It gives consumers a financial stake in choosing lower cost plans, an experience that we believe can help shift many people to lower cost health plans.

The Health Security Act encourages providers to form groups including, but not limited to health maintenance organizations, to deliver care at the lowest possible cost.

The Health Security Act builds on the experience of big companies and other large purchasers which have used their market power to bargain the best deal for their members. It creates health alliances that will bargain on behalf of small and medium-sized employers and individuals, allowing them to get the benefits of this market power now limited to large firms.

It reforms the insurance markets by requiring community rating. It eliminates cherry picking and preexisting condition restrictions, and the selection of people in favorable groups to the exclusion of others. It provides for more information which should make choices easier for those who have to choose.

A standard benefit package will make it easier to compare plans that are producing the same thing. It will provide information on outcomes so consumers know what they are buying. The primary reliance in the Health Security Act relies on changing the incentives to reduce cost growth.

The premium caps we regard as a backstop, not a primary reliance, but it is a backstop which we feel is needed. We believe that universal coverage will end job lock, and welfare lock, and make it easier for people to move into higher paid employment.

The big question, which this hearing addresses is how do we pay for all this. Remember that most of the costs of the new plan would be paid, as they are now, through premiums paid by employers and individuals. But there are significant new costs to the Federal Gov-

ernment especially for the subsidies to make the insurance universally affordable and for additional benefits.

We believe that health care reform can make an important contribution especially in the future to reducing the Federal budget deficit and that we have identified more than enough revenues and savings to pay for the plan.

Let me draw your attention to Chart 1, just to remind us of the deficit problem and how health care fits into it. The top line, which is labeled "Where We Were," is how deficit projections looked when the Clinton administration came into office. They were headed up. With the President's economic plan, which we all worked on together and which the Congress passed, that prospect has been erased.

The line labeled "Mid-Session Review" is our latest estimate of what the deficit will be as we follow the plan voted by the Congress. It erases the increase, it gets the deficit coming down and then leveling off. Unfortunately the deficit if we do nothing more will go up again particularly beyond the year 2000. It will go up again primarily because health care costs, if not contained will be rising faster than Federal revenues are increasing.

It is for that reason that we believe the health care plan must make a contribution to reducing the deficit. The lower line labeled "Mid-Session Review With the Health Care Plan" indicates that we believe that passing the Health Security Act would make that deficit line finally come down, not go up again.

Let me turn to the specific impact of the Health Security Act on the Federal budget. If you will turn to the second chart, it summarizes what this plan would cost in the column labeled "Use of Funds," and where we would propose to get the money. Starting from the bottom of the column labeled "Use of Funds," the first cost that would be imposed over this 6-year period to which this chart applies is for public health service activities and administrative costs of the new system, all together about \$53 billion.

A significant portion of this, about \$18 billion, would be additional public health spending. These expenditures will be designed to make it possible for those who have the new insurance benefit recipient to actually get service. The money will be used to increase the outreach, add funding as well for WIC, and for prevention research at NIH. This category includes start-up grants to the States to get the alliances started. It includes investments to help the Veterans' Administration medical system make the transition to a more competitive environment, as well as funds to cover the service of advanced practice nurses for Medicare beneficiaries.

Second, under the heading "Long-Term Care," we are covering substantial new benefits including the new home and community-based service program for the disabled, liberalized spend-down rules for the Medicaid-eligible institutionalized, and tax incentives for the purchase of long-term care insurance.

Third, at a cost of about \$66 billion, we are adding a benefit under Medicare for prescription drugs. Our plan introduces a prescription drug benefit under Medicare that is similar to the standard benefit package that all other Americans, those under 65, would have.

The Medicare benefit would have a \$250 deductible and 20 percent coinsurance with a \$1,000 annual limit on out-of-pocket spending on drugs.

Next we have the cost of making insurance more affordable to the self-employed by improving their tax deduction to 100 percent rather than the current 25 percent. Then—and this is really the largest and most complicated of the new costs—are the new subsidies or discounts for employers to make this insurance affordable.

What is shown in this chart is the net cost, but to understand it better I think it is useful to turn to chart 3 to look at the full range of subsidy costs. There would be subsidies for families, for businesses, for early retirees, which add to a total, including a \$44 billion cushion to make sure that we have allowed enough in the budget for these estimates of \$349 billion. Not all of that shows up in the previous charts because some of it is offset in the Federal budget by the amount of benefits for Medicare Medicaid recipients who are working and receiving benefits through the employer-based system albeit with some subsidies. These savings to the Federal Government would total over this period \$188 billion. The net, we believe would be about \$161 billion.

If we turn back then to chart 2, that gives us a total new cost to the Federal Government over this period of \$351 billion.

How are we going to pay for that? Well, we are going to pay for it in a number of ways which we believe have been very carefully and as accurately as possible estimated the sources of funds exceed the costs by about \$58 billion over this period, so that there would be a significant contribution to deficit reduction. If we turn to the sources of funds, first we have Medicare savings and Medicare changes, which have been very fully specified, and which total \$124 billion.

We have identified a set of 28 policy changes that would achieve this amount. These policy changes include reductions in the payment rates to providers as well as proposals to control utilization.

Mr. Vladeck walked through those in great detail last week and I will not do so though I will remind you that we have also included a proposal to relate the part B premium to income for high-income Medicare beneficiaries. These spending reductions imply a moderate decline in the extremely rapid baseline growth of the Medicare program.

We certainly wouldn't be wiping out the growth of the Medicare program. It would still be growing at a very substantial rate as shown in the last chart, but the rate would be moderated from the recent 11 percent growth per year in Medicare to under 8 percent by the end of the decade.

We are also, to go back to the previous chart, counting two kinds of Medicaid savings. The Health Security Act would provide all Americans with health coverage and therefore would nearly eliminate uncompensated care. This will allow the replacement of Medicaid disproportionate share payments with a smaller special reserve of funding to be directed toward hospitals that treat large numbers of low-income people including undocumented aliens.

In addition, the growth in alliance premiums paid by Medicaid on behalf of cash recipients will be constrained to grow at the same rate as private sector premiums. This is feasible because under our

plan Medicaid recipients will be receiving health care services in alliance health plans like Americans with private insurance.

Then we have added a tobacco tax and an assessment on corporations that choose not to participate in the alliances, but nevertheless share the general benefits of research and other government services and benefit from the elimination of uncompensated care costs in their premiums. That is a total of \$89 billion.

There are also very significant savings to be anticipated in other Federal programs from the new plan and from controlling the rate of growth of health care costs. The Veterans Department and Department of Defense programs are principal among them.

We also anticipate significant other revenue, about \$86 billion on balance. The Treasury projects that health reform will lower insurance premiums relative to our baseline projections and thereby raise taxable income and tax revenue. Changes in the tax treatment of health insurance will also lead to increased revenues.

Finally there will be a modest reduction in debt service cost. This adds to a total increase in funds available to pay for the plan of about \$409 billion.

Dr. Ken Thorpe is going to be here after me to talk in more specifics about how we made the estimates to get to these numbers. Let me simply say that we are very eager to share this information with you.

I am as sorry as you are that we have taken as long as we have to get the bill to its final stage, into print, and up here last Friday, but it is a very complicated effort and we were eager to work with the Congress to improve the bill. That is why the original September submission was a draft and not a final bill. We believe that we have made significant improvements in that bill by interacting with the Congress. That necessitated substantial numbers of reestimates and recalculations.

We have done those and we are eager to share the documentation with you as soon as we can get it all written down, printed, and ready to be shared. We will do that.

Finally, Mr. Chairman, let me just say a word about how we believe these deficit savings will be protected. Are they real? How do we know that and what do we anticipate doing?

There are several reasons why we think these deficit reductions will materialize and may be even exceeded. First, we tried to be as conservative and realistic as we possibly could in estimating the costs. We often had alternative estimates and took the more conservative of the options.

Second, as I said earlier, we have set targets for the rates of growth of premiums in the alliances. If competition alone does not keep the premium growth within the targets, and we are hopeful that it will, the premium caps will be triggered.

Third, we have made conservative assumptions about the speed at which States would come into the new system. We are not assuming that they are all ready and will be jumping in tomorrow. They will come in gradually over a period of 3 years. We believe that this will give them time to get the alliances up and running and for the States to learn from each other as they share this experience.

Fourth, we added to our estimate of the subsidy costs a 15 percent or about \$44 billion cushion to cover contingencies or behavioral changes that are very difficult to anticipate.

Finally, we did not make the subsidies an open-ended entitlement. We believe that our estimates are conservative and reasonable, but if for some reason it appears that the caps will be breached, the Congress and the administration will have to focus on the issue, debating it and acting and deciding what to do.

In sum, Mr. Chairman, we have worked hard on this bill and on these estimates and we are very eager to talk to you about them, to share our numbers and to work together as the Congress debates this very important change in our Nation's health system.

Thank you.

[Testimony resumes on p. 26.]

[The prepared statement and charts of Ms. Rivlin follow:]

STATEMENT OF ALICE M. RIVLIN
DEPUTY DIRECTOR
OFFICE OF MANAGEMENT AND BUDGET
SUBCOMMITTEE ON ENERGY & COMMERCE
UNITED STATES HOUSE OF REPRESENTATIVES
NOVEMBER 22, 1993

Mr. Chairman, it is a pleasure to be here today to discuss the Clinton Administration's health care reform plan. No one needs to remind this Committee that our health care system is in crisis. While the quality of health care in the United States is the best in the world for those who can afford it, the total cost of care is unnecessarily high and rising at frighteningly rapid rates. Moreover, millions of Americans are without adequate health care coverage and millions more live in fear that they will lose their health insurance.

The challenge before the Congress is to develop a plan that preserves what is best in the current system while controlling costs and providing universal access to high quality health care. The plan presented to you by the President and the First Lady does that. It controls costs and guarantees health security: For the first time, every American will have health insurance coverage with a comprehensive package of benefits that can never be taken away.

I would like to focus first this morning on the vital part the Administration's health reform plan plays in our overall strategy to improve the future vitality of the American economy. Then I would like to turn to the impact of the plan on the Federal budget -- what new costs would be incurred and how we propose to pay for them.

HEALTH REFORM IS AN ECONOMIC IMPERATIVE

If we are to have the productive, high wage economy that we all want, we must reform the health care system. Indeed, health reform may be the single most important change that is needed to make the economic future brighter for our children and grandchildren.

The current health financing system threatens America's economic future in three ways: (1) health costs are unnecessarily high and rising too rapidly -- draining resources from more productive uses to support an inefficiently organized health care system; (2) the rising costs of government health programs add to the Federal deficit and reduce national saving; and (3) health care insecurity locks people into existing jobs or onto welfare

rather than allowing them to move into more productive employment.

The United States spends more of its Gross Domestic Product (GDP) on health care than any other country in the world. The numbers bear repeating: Today, 14% percent of our GDP goes for health care, and by the end of the decade, we could be spending an almost unthinkable 18% of GDP on health care. No other country spends more than 11% of its output on health care. During the last decade, our real per capita health care costs grew at a rate of 4.4% per year, while our real per capita GDP grew at only 1.6% a year. By any measure, we are spending too much of our income on health care.

Inflation in health care costs is robbing government budgets of scarce resources needed for critical investment in our future -- education, job training, infrastructure, and technology development. The Federal government devotes 19% of its budget to health care right now. If current projected trends continue, that percentage will rise to 25% by fiscal year 1998. This means that almost 50% of Federal spending growth between 1993 and 1998 will be for health care. Make no mistake about it: getting Federal health spending under control is essential to long-run deficit reduction.

Despite all this spending, 37 million Americans are uninsured, and increasing numbers of Americans are vulnerable to losing their insurance upon developing a serious illness or medical problem. Pre-existing condition restrictions lead to "job lock": surveys have shown that 30% of workers restrict their search for better jobs for fear of losing their health insurance coverage.

RESTRUCTURING THE MARKET FOR HEALTH CARE

The Health Security Act preserves and strengthens the current system of employer-based health insurance. It would change the way the health care market works in fundamental ways. First, it would give consumers a financial stake in choosing the lowest cost health plan and information on which to base that choice. Employers make defined contributions that equal 80% of the average cost of health plans in their area. Households are responsible for the difference between the cost of the plan they select and their employer's contribution. Experience has shown that employees choose lower cost plans when they are given the financial incentive to do so.

Second, the Health Security Act encourages health providers to join together in groups that will provide care as effectively as possible and reduce unnecessary costs in order to compete for members.

Third, the Health Security Act builds on the experience of big companies and other large purchasers of health care that have demonstrated their ability to bargain hard with health plans to get the best price. The Act requires the States to set up regional health alliances to bargain on behalf of individuals and small- and medium-sized businesses. New health alliances would use their market power to obtain for their members the favorable prices now available only to employees of large companies.

Fourth, the Health Security Act reforms insurance markets by requiring community rating. Risk selection will be eliminated by:

- A comprehensive benefits package, to homogenize the product and make shopping among health plans easier for consumers;
- Community rating to remove the incentive to select healthier enrollees, with risk adjustment to compensate plans that have a disproportionate share of higher risk individuals;
- Ending pre-existing conditions restrictions, medical underwriting, lifetime limits, and other techniques that deny many Americans coverage.

Providers and insurers will also be required to report interpretable medical outcomes. This information will help Americans assess the relative quality of competing plans. In addition, it will provide insurers and providers with incentives to be efficient while meeting the needs of their customers and patients.

Introducing these new market incentives should lower the rate of growth of health care costs. The most effective cost control known to economists is to let producers compete and consumers choose. Our targets for the growth of insurance premiums should be viewed as backstop devices that will probably never be needed once insurers, providers and consumers learn to make managed competition work.

With universal health insurance coverage Americans will no longer be afraid to change jobs because they would risk losing their health insurance. By ending "job lock", health security will increase economic flexibility and improve productivity.

No longer will Americans be afraid to leave welfare because they would lose Medicaid benefits. A welfare mom who gets a job will not have to turn it down to protect her children from uninsured illness. The end to "welfare lock" will also promote the health of our economy.

EFFECTS OF HEALTH REFORM ON THE FEDERAL BUDGET DEFICIT

The President's Economic Plan, which the Congress approved in August, will bring about a significant reduction in the Federal budget deficit -- \$500 billion from FY 1994 to FY 1998. But we have not conquered the deficit. Health reform is absolutely essential to further deficit reduction. [Chart 1]

The President's health reform plan will get Federal health expenditures under control, although it will take time. The bulk of the savings in the President's plan occurs after the end of 1997, once the alliances are fully up and running.

In the interim some Federal expenditures will rise. After all, extending coverage to the uninsured has some cost, as do the new benefits for Medicare recipients and the start-up costs of establishing the alliances. The President's plan offers a responsible means of financing the new health benefits it provides.

FINANCING THE HEALTH SECURITY ACT

Now I would like to turn to the specific effects of the Health Security Act on the Federal budget: what we propose to spend on the new system, and how we propose to finance it. [Chart 2]. Let me make clear that in our system of health alliances, 74% of total health insurance spending comes from the same place it comes from now: the private sector -- businesses and households paying insurance premiums.

The Health Security Act proposes new Federal outlays in the following 5 areas:

1. Expanded public health service activities and administrative costs of the new system -- \$53 billion. Approximately \$18 billion of these funds will be devoted to new public health programs such as outreach and enabling services to ensure that underserved populations have access to the new system, increasing funding for the WIC program, and enhanced funding for prevention research at NIH. This funding also supports grants to states for alliance start-up costs. Included in this segment are investments to help the VA system make the transition to a more competitive environment, as well as funds to cover the services of advanced practice nurses for Medicare beneficiaries.
2. Long-term Care -- \$62 billion. There are three major components of our long-term care initiative: (1) a new home and community-based service program for the disabled; (2) liberalized spend-down rules for the Medicaid-eligible institutionalized; and

(3) tax incentives for the purchase of long-term care insurance. This program will be phased in from FY 1996 to FY 2002.

3. Medicare drug benefit -- \$66 billion.

As you know, many elderly Americans are worried about paying for prescription drugs, prescriptions that are needed to improve the quality of their lives, prevent more serious illnesses and help them avoid hospitalization. Our plan introduces a prescription drug benefit under Medicare that is very similar to the standard benefit package for all Americans under 65: \$250 deductible and 20% coinsurance with a \$1000 limit on out-of-pocket spending for the year. This means that seniors will no longer have to worry about foregoing necessary prescriptions in order to buy food or pay the rent.

4. 100% Tax Deduction for Self-Employed Health Insurance -- \$10 billion.

Historically, self-employed individuals have been penalized by being unable to deduct all of their health insurance premiums, while their counterparts in corporate business and industry have been able to deduct the full amount. Our proposal will "level the playing field," and extend full deductibility to the self-employed. This issue has had bipartisan support for some time now. The total cost of this benefit is \$10 billion over five years.

5. Net new subsidies or discounts for employers and households -- \$161 billion [Chart 3].

Premium discounts are available to the following types of households:

- Working families with incomes less than 150% of poverty;
- Nonworking families with unearned incomes less than 250% of poverty
- Nonworking families which include early retirees;
- Self-employed families with relatively low incomes.

To share the cost of insuring workers equitably across different firms, the following firm level guarantees are available:

- no firm will pay more than 7.9% of payroll, and most will pay less;
- firms with fewer than 75 employees with low average wages will pay as little as 3.5%, depending on their exact size and average wage.

Finally, we provide out-of-pocket discounts for individuals who earn less than 150% of poverty and who do not have access to HMOs, to compensate them for the higher expected cost of fee-for-service coverage.

Our best estimate of the discounts was \$305 billion over the 6 years from FY 1995 to FY 2000. To be on the safe side, we added 15% (about \$44 billion) to this estimate to cover possible behavioral changes that are difficult to model directly. Simulations of those potential behavioral changes suggest that our cushion is more than adequate to cover those extra subsidy costs.

With the cushion, we estimate the subsidies will cost \$349 billion over 1995-2000. This total, however, is offset by \$188 billion in other Federal savings, so that the net cost of the premium discounts to the Federal Government is \$161 billion, or \$117 billion plus the \$44 billion cushion.

The offsets come from three sources. First, \$28 billion will be saved as working Medicare beneficiaries get employer-sponsored insurance and Medicare becomes a secondary payor for them. Second, some current Medicaid enrollees will leave the Medicaid program entirely and get their coverage through regional alliances. This will result in \$85 billion in direct Federal savings as Medicaid rolls shrink. Third, states will be required to maintain their current financial effort on the non-cash Medicaid population in the form of payments to the regional alliances for the express purpose of offsetting the Federal subsidy liability. \$75 billion is the sum of these payments over FY 1995 to FY 2000. Thus, the net cost of discounts is \$161 billion.

Sources of funds:

We propose to pay for these new Federal outlays in the following 6 ways [Chart 2]:

1. Reductions in the rate of growth in the Medicare program -- \$124 billion.
 Medicare has been growing at a rate of almost 11% per year. We have identified a set of 28 policy changes that will achieve \$124 billion in savings. These policy changes include reductions in the payment rates to providers, as well as new proposals to control utilization. We have also included a proposal to income-relate the Part B premium for high-income Medicare beneficiaries -- singles with income of \$100,000+ and couples with incomes of \$125,000+.

[Chart 4] These spending reductions imply a moderate decline in the extremely rapid baseline growth of the Medicare program. Our plan would reduce the rate of growth in Medicare from its current annual rate of 11% per year to less than 8% by the end of the decade -- even while adding new coverage for prescription drugs.

2. Medicaid savings -- \$65 billion.
 The Medicaid savings counted here result from two sources. The Health Security Act will provide all Americans with health coverage, and therefore it will nearly eliminate uncompensated care. This will allow a replacement of Medicaid disproportionate share payments with a much smaller special reserve of funding to be directed toward hospitals that treat large numbers of low-income people, including undocumented aliens. In addition, the growth in alliance premiums paid by Medicaid on behalf of cash recipients will be constrained to grow at the same rate as private sector premiums. This is feasible because under our plan, Medicaid recipients will be receiving health care services in alliance health plans, like other Americans with private insurance.
3. Tobacco tax and corporate assessment -- \$89 billion.
 These revenues will come from a combination of the increased tobacco tax, which the Treasury Department estimates will raise \$65 billion in revenues, and a 1% of payroll assessment on the large corporations that will benefit from reduced cost-shifting, and thus lower health care costs, in the new system. Treasury estimates that this assessment will raise \$24 billion.
4. Savings in other Federal Programs -- \$40 billion. As the Federal health programs -- Veterans' Administration health, Department of Defense health, Federal Employees Health Benefits program, and the Public Health Service -- are integrated into the reformed health system, we expect savings from lower expected premiums and new revenues. For example, the VA will receive new revenue

from previously uninsured veterans, FEHB will pay lower premiums for many of its workers compared to today, and DOD will share in premium contributions for the employed dependents of military personnel. These savings estimates are not derived from reductions in services; in fact, we believe that the services provided to these beneficiaries will be improved.

5. Other Revenue Effects -- \$86 billion.
The Treasury Department projects that health reform will lower insurance premiums relative to our baseline projections and thereby raise taxable incomes and tax revenue. Changes in the tax treatment of health insurance will also lead to increased revenue.
6. Debt Service -- \$4 billion.
Finally, modest savings in debt service, about \$4 billion, will be realized as the deficit is reduced.

HOW THE NUMBERS WERE DERIVED

There are three broad types of estimates underlying the summary budget data:

1. Estimates of outlay effects for existing programs;
2. Estimates of revenue effects;
3. Estimates of new subsidies, or premium and out of pocket discounts.

Standard OMB methods were used to determine the first type of estimates. OMB budget examiners worked in conjunction with HCFA and SSA actuaries, as well as agency program personnel, to "scrub" the estimates and account for the many interactive effects among programs.

The Treasury Department estimated the revenue effects and the tax-related provisions of the Medicare savings package, as they would for any Administration proposal.

A unique interagency process produced the subsidy estimates. Economists and actuaries from many different departments and agencies -- including the Health Care Financing Administration, the Agency for Health Care Policy and Research, the Departments of Treasury and Labor, the Council of Economic Advisers, and OMB -- worked to develop a consensus on analytical methods. Experts from private think tanks and consulting firms were also involved. A team of private actuaries and health economists was brought in to evaluate and make suggestions about our estimation methods and data sources.

Estimating a complete health care system overhaul is obviously an immensely complex task. Reasonable people can differ about the many assumptions that must be made. But the thing I want to make clear is that our team consistently tried to err on the side of conservatism.

HOW ARE THE DEFICIT SAVINGS PROTECTED?

We estimate that the total new cost of the Health Security Act to the Federal government will be \$351 billion, and we will have \$409 billion in revenues to finance these new costs. This will leave \$58 billion in deficit reduction over the FY 1995 to FY 2000 period. We believe these numbers are solid -- because of the process we used to produce them, and because of the safeguards we have built into the new system. Let me outline some of these safeguards.

First, we tried to be as conservative and realistic as we could in estimating the costs. For example, we asked two agencies to estimate the cost of the premiums for the comprehensive benefit package. An interagency team spent months analyzing the estimates, and we chose to use the higher estimate from HCFA. Furthermore, after the initial estimating was done, the agencies spent several weeks in an intensive "scrubbing" of all the numbers to vet the assumptions and make sure we accounted for interactive effects.

Second, we have set targets for the rate of premium growth in the alliances. If competition alone does not keep premium growth within the targets, premium caps will be triggered. If the combination of competitive forces and premium caps work as we expect they will, then future savings will grow, as the rising trend in health costs is broken.

Third, we made conservative assumptions about the speed at which states would come into the new system. We assumed that states representing 15% of the population will come into alliances during FY 1996; another 25% (for a total of 40%) will come into alliances during FY 1997; and the remaining 60% will be phased into the new system by January 1, 1998. We believe that these assumptions are realistic, and that they give the states enough time to get alliances established and to learn from each other.

Fourth, as I discussed earlier, we added 15% to the estimate of the subsidy costs -- about \$44 billion -- to cover potential behavioral changes that are difficult to model.

Finally, we did not make the subsidies an open-ended entitlement program. We believe that our estimates of the subsidies are conservative and reasonable, particularly in view

of the 15% cushion and the mechanism allowing excess funds to be carried forward and applied to the next year's cap. It is unlikely that the caps will ever be breached. If there were a problem, however, because of a severe downturn in the economy or a massive economic dislocation, it would mean we had a serious situation that the President and Congress would have to address. That is how it should be.

CONCLUSION

Mr. Chairman, we have begun one of the most important debates in the history of this country. It will take place not only in the committee rooms and the chambers of the Congress but in newspapers, in meeting halls, and over kitchen tables throughout the nation.

Over the last few decades in this country, the health care issue became a bigger and bigger problem. It was ignored until it became a crisis, as costs for families, businesses, and government spiraled out of control, as the number of uninsured Americans grew, and as more and more families came to fear the loss of their insurance coverage.

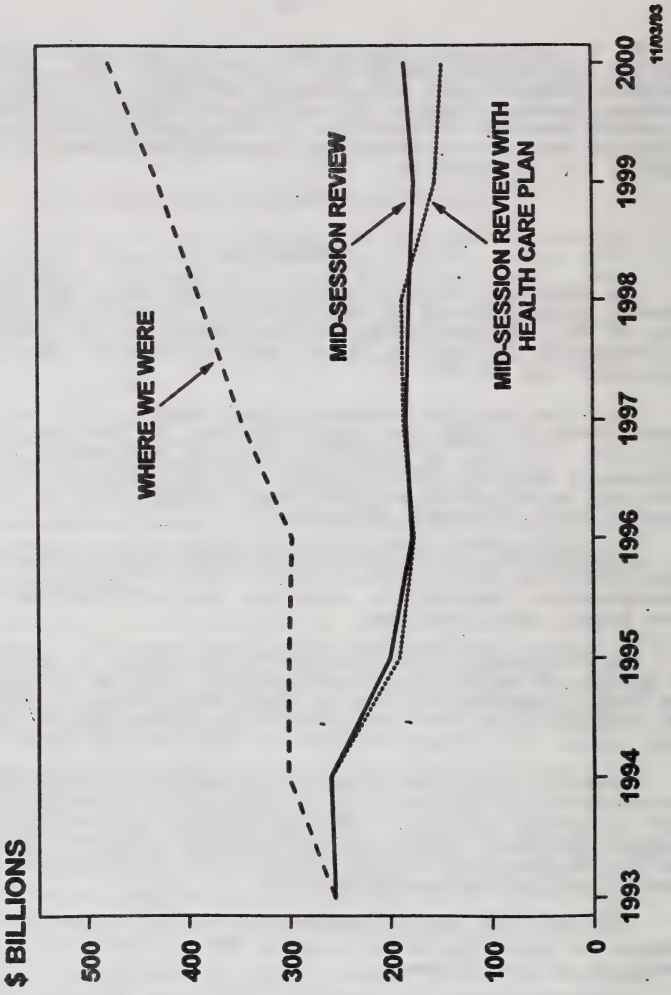
Suggestions, ideas, and reform concepts abounded, but until this President, nobody presented the kind of specific, comprehensive, responsible, detailed, paid-for plan that you now have before your Committee.

As the national debate proceeds, we expect to be challenged on policy; we expect a strenuous and far-reaching discussion of how best to achieve the goal of comprehensive health care reform. The Administration does not pretend to possess divine wisdom on this issue. We welcome alternative proposals and views.

However, when other plans are presented, we hope they will be subjected to the same kind of rigorous analysis to which we have subjected this plan. We hope you will insist that their numbers have been thoroughly examined and analyzed. That way, we can all be sure that this is a discussion over policies and issues, not numbers and statistics.

The American people deserve that kind of debate as we address an issue that will directly affect every one of them every day of their lives.

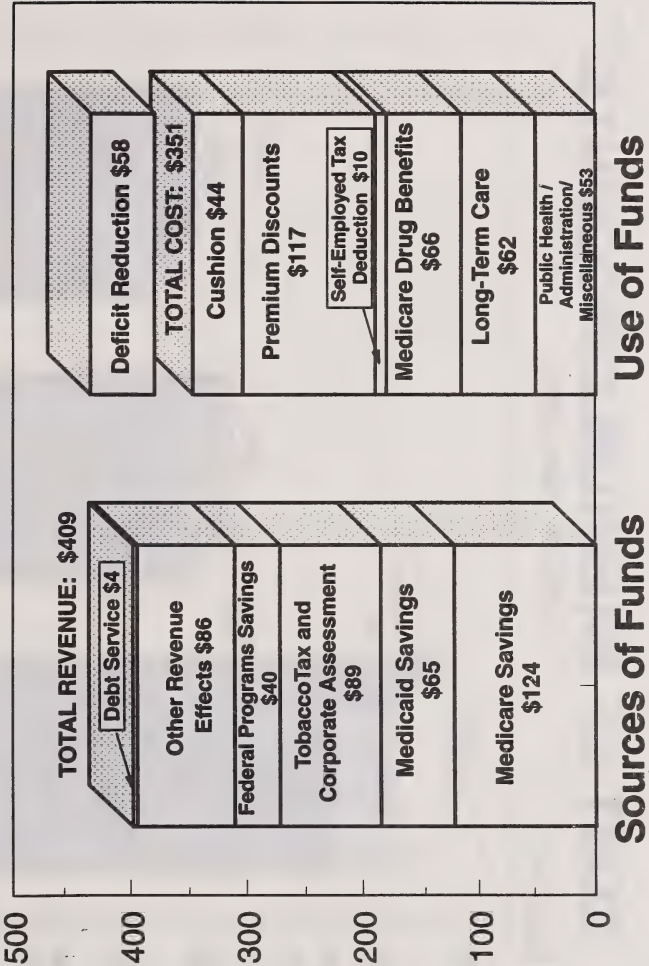
ALTERNATIVE DEFICITS 1993 - 2000



Financing Health Care Reform

Totals: 1995-2000

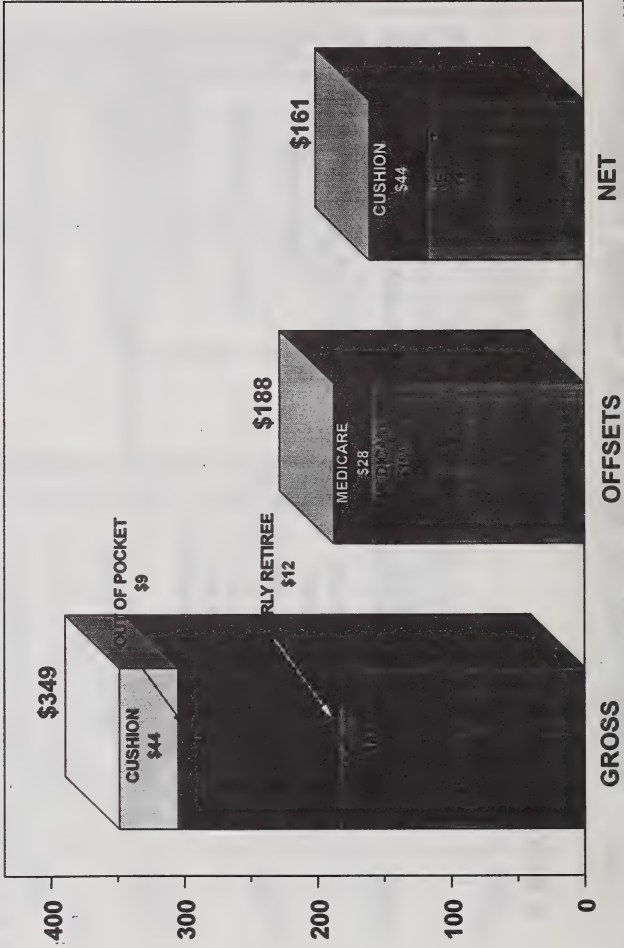
\$ Billions



COST OF PREMIUM DISCOUNTS

TOTALS: 1995 - 2000

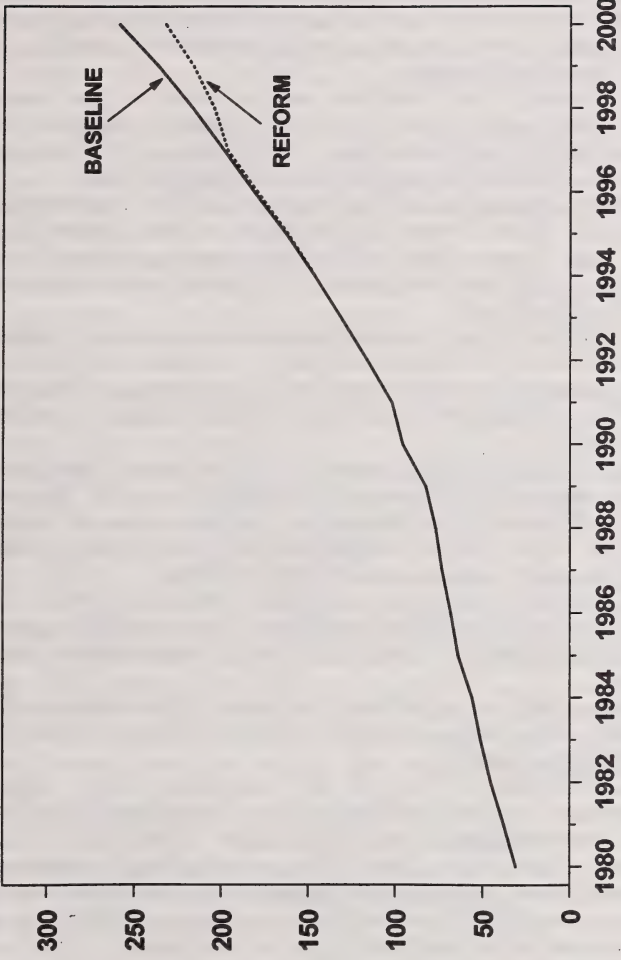
\$ BILLIONS



11/03/93

MEDICARE SPENDING UNDER HEALTH CARE REFORM

\$ BILLIONS



11/03/93

Mr. WAXMAN. Thank you very much, Dr. Rivlin, for extensive testimony explaining this fundamental part of the proposal. Today the House is scheduled to vote on the Penny-Kasich amendment which would reduce Medicare outlays by over \$40 billion over the next 5 years and lower the caps on discretionary spending by \$53 billion over the next 5 years.

On Friday, the President sent a letter to the House and Senate leadership urging that the amendment be defeated because among other things it claims over \$40 billion of the potential Medicare savings needed for any serious health care plan.

This morning in a Washington Op Ed, Secretary Shalala made the point that "absent systemwide reform, there is a good chance that the Penny-Kasich Medicare savings would be illusory and would simply be swallowed up by continuing double-digit inflation and medical costs."

Dr. Rivlin, the President's plan relies on \$124 billion in Medicare savings to help finance universal coverage and long overdue Medicare prescription drug benefits. If we enact the Penny-Kasich Medicare cuts, where will we find the \$40 billion to replace this lost financing?

Ms. RIVLIN. I don't know, Mr. Chairman. That is the problem. I think we need the savings including the ones that are detailed in Penny-Kasich, many of which are the same, as Congressman McMillan, I pointed out earlier, as the ones we are proposing. But we need those to finance health care reform.

It doesn't make sense to do this and then decide whether we are going to have health care reform. It should all be part of a package. We should look at the whole health care system and decide what to do.

There can be significant savings in Medicare and Medicaid we believe, but they should be part of a entire effort to reform the health care system.

Mr. WAXMAN. One of our panelists later this morning Dr. Wilensky, has been critical of the financing of the President's plan. She characterized it as "tooth fairy" financing. In a recently published article, she argues "We systematically underestimate future expenditures, particularly those associated with new programs, and we systematically overestimate savings, particularly when they are associated with cuts from ongoing programs."

Dr. Rivlin, you served for 8 years as the Director of CBO. You are now managing estimates for OMB. Do you think you have underestimated future expenditures and do you think you have overestimated savings?

Ms. RIVLIN. No, I don't. I share Dr. Wilensky's nervousness because the past record is not very encouraging. Early estimates for Medicare and Medicaid, there was consistently underestimated of the cost of those programs. But I think we have worked very hard not to repeat those mistakes.

We have tried to be very conservative in our estimates and we are proposing ways of controlling the costs. When you look at what was estimated under Medicare and Medicaid, you see that there were no cost controls. The government was adding to the demand for medical care without putting in place any changes in incentives or new ways of controlling the cost.

So we have tried to change. We put forward a plan that would change the market incentives in a significant number of ways and that also makes very conservative estimates of the impact of those changes on health care growth.

Now, we could have underestimated, we could have overestimated but we have done the best we could to avoid the mistakes of the past.

Mr. WAXMAN. Most Americans will be trying to figure out what the President's plan means to their family budgets and most businesses will be trying to figure out what it means for their bottom lines. Obviously there is a lot of inequity in the way we finance health care today.

Some people are choosing not to insure while others are paying the cost for caring for these free riders. Many more simply can't afford to find coverage. Under any universal coverage plan, those who have chosen not to buy coverage will necessarily end up paying more.

As the President said in his address to the Congress exactly 2 months ago, no one should think he is going to get a free ride; they have to pay for it. My question is, can you tell us, under the President's financing proposals, how many families will pay more and get less coverage than they currently have? How many will get more coverage than they now have or will pay the same or less, and what can you tell us about each group?

Ms. RIVLIN. When you look at those who now have insurance through their employers, that is most people, but not everybody and have tried to analyze how that group would be impacted by this plan. When you look at the insurance premiums that they would pay and the change in their out-of-pocket costs, we believe that about 70 percent would pay the same or less. About 30 percent would pay more, although many of those people would get better benefits. They have plans now which are inferior to the standard benefit package.

Mr. WAXMAN. Thank you.

Mr. Bliley?

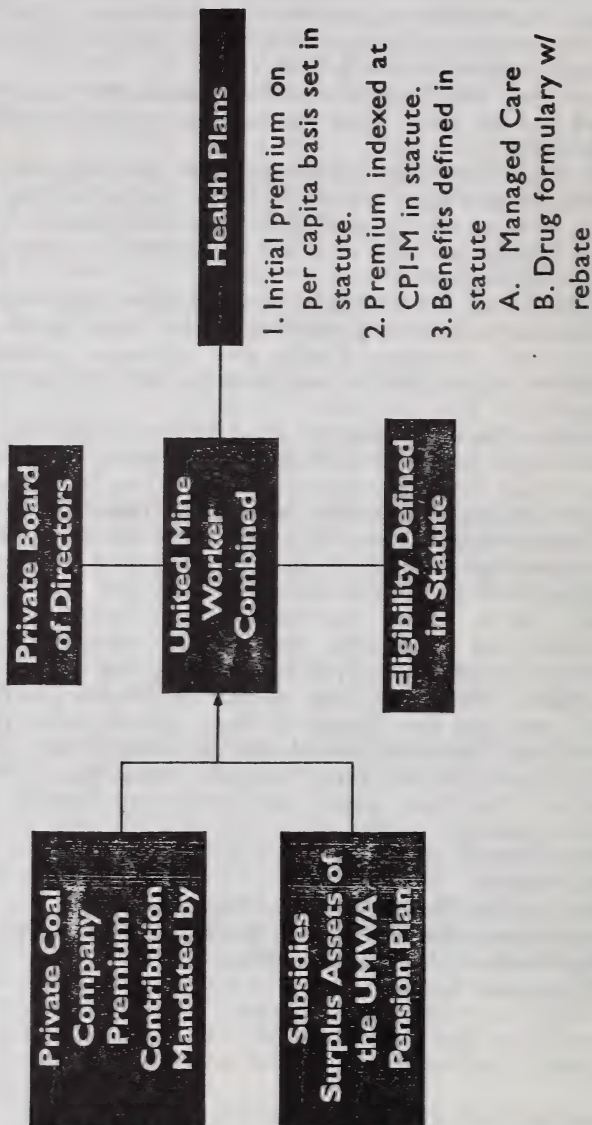
Mr. BLILEY. Thank you, Mr. Chairman.

I ask unanimous consent to distribute two charts.

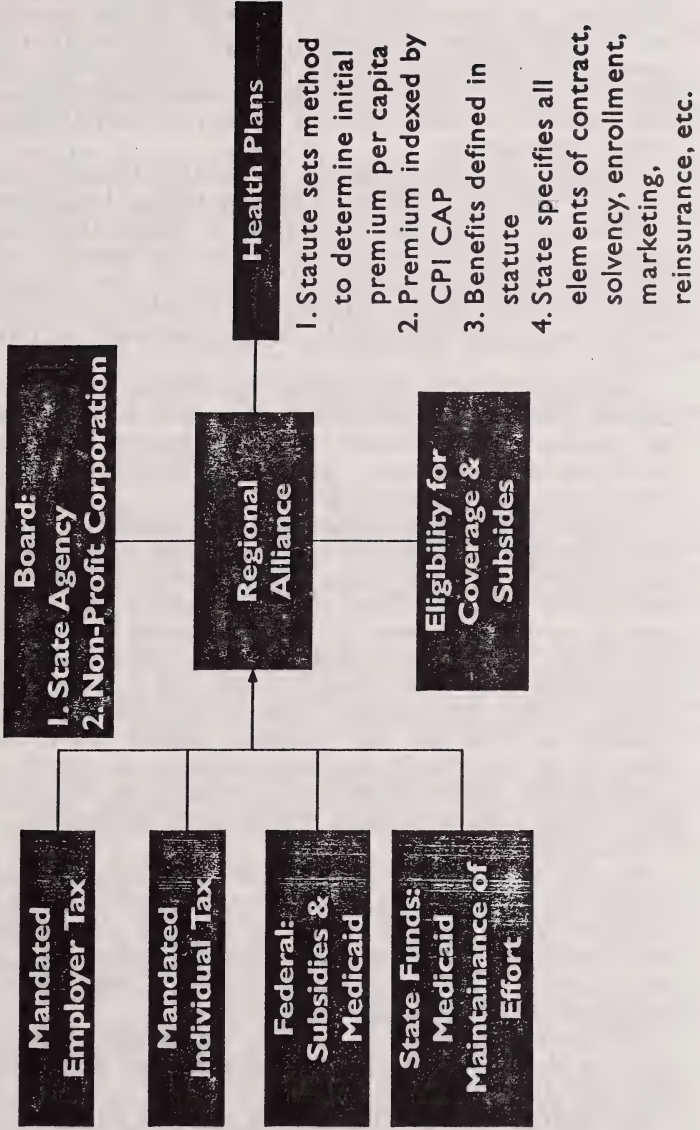
Mr. WAXMAN. Without objection.

[The charts follow:]

United Coal Miner "Orphan Retiree" Health Benefits



Alliance Structure -- Administration Plan



Mr. BLILEY. Dr. Rivlin, the administration health care proposal will have the Federal Government reallocating hundreds of billions of dollars or approximately 14 percent of the economy. If allowed to do so off budget, Congress and the public will be deprived of an essential measurement of the fiscal and economic impact of these policy decisions. This is a critical issue because the administration's reform proposal calls the employers payroll tax a non-Federal private transaction.

Although universal coverage is popular, taxes are not. I am fully aware of that, But I strongly disagree when legislation invokes the sovereign power of the government to compel the payment of funds defines a class of beneficiaries, guarantees specific benefits and establishes a Federal regulatory apparatus, that legislation has created a Federal activity financed by a Federal tax. Rather than debating semantics fortunately in this instance we have a model to go by.

Last year Senator Rockefeller introduced the United Coal Miner Orphan Retiree Health Benefit Plan and it is almost identical in my opinion in its structure to the administration plan. First it said to all the coal operators, "you must contribute a fixed amount of money into this benefit program."

It defined the beneficiaries and it defined the benefits and gave the Secretary of HHS the right to index this contribution, which they called a private transaction. However CRS, OMB and CBO scored this as a tax. They said just what I said before—when you use the sovereign power of the government to compel the payment of a fee for a specific purpose defining benefits for the miners, defining what they were, that is a tax and it is on page 1153 of the annex to the 1994 budget. Now would you please comment—my question is, how can the employer payroll tax in the President's plan not be included in the Federal budget as a tax?

Dr. Rivlin, please limit your comments to this example and not the Federal minimum wage, which is not analogous.

Thank you.

Ms. RIVLIN. I think we all have the same objective here. We would like the public to be able to see exactly what is going on, and to show in the Federal budget, if this bill were passed, what was being paid and by whom, and what the money was going for. And we thought: What is this like? It is not really like anything we have in the Federal budget right now.

We have a number of entities which are displayed in various ways in the Federal budget-like government sponsored enterprises. But this is not exactly like that.

Mr. BLILEY. Has it differed from the coal miner fund?

Ms. RIVLIN. What we are proposing is a much more comprehensive restructuring of the whole health care system. The alliances are not created by the Federal Government, and they are created by States.

Mr. BLILEY. But are the States creating them on a mandate from the Federal Government in this bill?

Ms. RIVLIN. Yes, but that is a different kind of thing. They are allowed to create them. They don't have to create them. They can go to single-payer. But I think the question is: How do you show

this in the Federal budget? It doesn't make sense to say we will show some parts here and some parts there.

We would like to display how much is paid in premiums, and where it goes. And we are working out ways of doing that.

I don't think it is analogous to anything that goes on in the Federal budget right now. And therefore, we have to create a new way of displaying it.

Mr. BLILEY. Dr. Rivlin, isn't the bottom line you know there is not enough money in there to finance these alliances, and by taking it off budget, you are allowing the alliances to go back and raise the premium without coming back to the Congress?

Ms. RIVLIN. No. We are not saying that the Federal Government is going to finance the alliances. Most of the alliance revenue will come from employers. I don't even follow what you are saying there. They will not be allowed to raise the premium. The premiums are capped. We hope that they will go down, actually.

Mr. BLILEY. Thank you, Mr. Chairman. I apologize for going over.

Mr. WAXMAN. Mr. Wyden.

Mr. WYDEN. Thank you, Mr. Chairman.

Dr. Rivlin, I have great respect for you and all that you have contributed in this budget discussion for these many years. But I must tell you, I think the administration is making a big mistake in terms of glossing over the private sector draw in financing the system.

Look, for example, at your testimony on page 6. We have got six specific items on the funds, all about, you know, the government's role, and basically the private sector's role in all this just gets a sentence. It says, 74 percent of the money comes from the private sector.

I am curious, just so we can start this discussion with respect to the private sector, because it is clear they are doing the heavy lifting, do you all anticipate that 74 percent of the new system's funding is going to come from the private sector?

Ms. RIVLIN. We are saying that 74 percent of—let me look—

Mr. WYDEN. That is today's system. Today, the private sector puts up 74 percent of the money. Under the new system, will the private sector put up 74 percent?

Ms. RIVLIN. I don't know exactly what the number will be, but it will be very substantial. We are not shifting a major portion of the health care funding to the government.

Mr. WYDEN. Then let us talk about who is going to be directly paying for health coverage in the private sector after the mandate that wasn't paying directly before the mandate.

Ms. RIVLIN. Right.

Mr. WYDEN. Who are those people?

Ms. RIVLIN. They are firms and their employees who do not now offer insurance or who offer insurance that is inferior to the standard benefit package that will be mandated. That is a significant number of firms, mostly smaller firms. They will be paying more, and their employees will be contributing as well. Those costs will be made more affordable by the government subsidies. But there is no question that there will be some increased cost.

Mr. WYDEN. How much money will these new participants in the health insurance risk pool be contributing?

Ms. RIVLIN. I don't know exactly. We can provide that.

Mr. WYDEN. Dr. Rivlin, these are the gut questions. You are a specialist in the distributable effects of these kinds of key economic issues. And we have got to have these numbers. I mean, I want to continue—

Ms. RIVLIN. I am not withholding anything. I was asked to talk about the Federal budget impact today and I don't have all the information with me. But we are certainly eager to provide it.

Mr. WYDEN. I think today's discussion is on financing, and the fact is that the bulk of the money comes from the private sector. Tell us then, if you would, the 30 percent who are going to pay more, how much more are they going to pay?

Ms. RIVLIN. That depends on what their situation is now. Some of them have insurance that is not as good as what they will be getting, but they will be paying somewhat more. Some of them pay more because of community rating. They are the young and healthy. We are all for community rating because it helps people who are disadvantaged by the current system. Under community rating, some will pay more; the young and healthy.

Mr. WYDEN. Who will pay less under the administration's bill and how much less are they going to pay?

Ms. RIVLIN. Those who will be paying less are those who have insurance now which costs more than the administration's plan would cost. As we control the increases in cost, those companies and employees will benefit very significantly.

Mr. WYDEN. I would only say again that when we talk about who is going to win and who is going to lose, we need a better description of who we are talking about, because this is what our constituents are asking us at home. And when the administration comes in and devotes most of the time to government financing and then puts a sentence in, 74 percent of it is in the private sector, that is not going to be responsive to those of us who feel that the President's heart is in the right place, wants to do the right thing, but with the administration not giving us a straight assessment in terms of the numbers, we don't have what we need to answer our constituents.

Ms. RIVLIN. Mr. Wyden, I don't think there is anything unstraight about this. There are many aspects of this plan. If you ask the Deputy Director of the Office of Management and Budget to talk about the budget aspects, that is what you get. If you ask a different set of questions, we will be happy to answer those.

Mr. WAXMAN. Thank you, Mr. Wyden. Mr. McMillan.

Mr. MCMILLAN. Thank you. I would like to compliment the gentleman from Oregon for his line of questioning. I think it is right on target. Ms. Rivlin, I think the reason is there is no way you can estimate what the government subsidies are going to be, since they are interrelated with the level of mandates, and a definition of the magnitude of that problem.

So the impact on the Federal budget is very much dependent on what your assumptions are with respect to the mandates out there and who is going to pay more and who is going to pay less. I think

you know that. I think you have got assumptions about that. All we are saying is we would like to see them.

Ms. RIVLIN. I am saying we would be happy to provide them.

Mr. McMILLAN. Thank you. When?

Ms. RIVLIN. As soon as we can. We finished up—

Mr. McMILLAN. How about before lunch?

Ms. RIVLIN. Let me just say that I don't think the members of the committee really understand how hard it is to get all these numbers together. We finished this bill on Friday. And it meant a lot of recalculations. It is now Monday morning, and we are working very hard, through weekends, to get this all pinned down. And you act like we have somehow been bad children.

Mr. McMILLAN. Maybe that is the problem with government, it designs the programs and then decides what they are going to cost. If they did it the other way around, maybe we would be better off.

Ms. RIVLIN. This is only a question of getting a complicated set of calculations written down in a form in which we can transmit them to you. And that is not an instant possibility.

[The following information was received:]

It is important to remember that most workers receive health insurance through their employers today. Many employers that are currently providing insurance will find their per worker payment falling, partly from our insurance market reforms (e.g., community rating, lower administrative loads) and partly from our method of computing employer obligations. Some will find their per worker payment rising. On balance though, we are confident that the average business will pay a smaller percentage of payroll than it does now, and considerably smaller than it would have paid by the end of the decade if no reform was enacted.

Before explaining how our models investigated the various effects of our particular employer mandate, let me make clear exactly how an employer's per worker obligation is computed through an example. Suppose the actuarial value of the two adult family premium is \$4,400. The household is responsible for 20 percent, or \$880. This leaves \$3,520 for the employer's share. If the policy were purchased today with a 20/80 split, the firm would pay \$3,520 for each married worker with children. Since most employers pay more than 80 percent today, they would on average pay more than \$3,520 today.

The Health Security Act finances our employer mandate by spreading the cost of the employer share across all employers in the following way. Suppose that, on average, 50 percent of all two adult families have both spouses working. Then with 1.5 workers for each two adult family policy that needs to be paid for, precisely enough money will be raised in total if each employer pays $\$3,520/1.5 = \$2,347$ on behalf of each worker in a two adult family. Note, this amount is considerably lower than 80 percent of the actuarial value of the two adult family policy. This is why so many firms that are currently providing insurance to their workers gain under our plan. Some of these lower insurance costs are presumed to be passed on in the form of higher wages, especially over time. Since most workers are currently insured through their jobs, the aggregate wage gain is larger than the aggregate wage loss experienced by workers in firms that do not currently offer insurance. This is why the Treasury Department found net revenue gains from the mandate, increasing in size as the savings from our other reforms take greater hold later in the decade.

Turning specifically to the assumptions in our models, I enclose the document that describes the models and our premium and subsidy estimation in detail, "Methodology Description of Health Care Reform Premium and Discount Estimates." I will highlight the features of our models most relevant to the employer mandate.

1. From nationally representative surveys (the Current Population Survey and the National Medical Expenditure Survey), we know the family status, employment status, size of employer, industry, occupation, State of residence, and earnings of each worker. We also know how much the family unit spent on health care in total in the past, including premiums and out-of-pocket payments.

2. From these and other surveys (e.g., one conducted by the Health Insurance Association of America), we know how much health insurance premiums cost and how the cost is split between employer and employee. County Business Patterns data and a proprietary data set from a major consulting firm gave us estimates of the average wage for each type of firm (by firm size, industry, region, etc.).

3. From our eligibility rules and policy choices, we know (and alliances can accurately estimate) how many households or health insurance units (e.g., two adult families, one adult families, etc.) will be in the alliance, and how many workers there are, on average, in each household unit. This, combined with our premium estimates, allows us to compute the per worker obligation for each family status type.

4. Computer algorithms then "run" every worker in our survey through the model, comparing what the firm is paying today with what the obligation would be under reform. Recall that no firm is presumed to pay more than 7.9 percent of payroll, which we estimate from our knowledge of average wage and number of employees. Small, low wage firms are obligated to pay an even smaller share of payroll, as low as 3.5 percent in some cases.

5. Our behavioral assumptions about this are fairly minimal. We assume that firms will want to minimize their own payment, always choosing the lowest cost option of meeting their obligation. We assume that workers will want to maintain the actuarial value of today's health insurance policy, and that they are willing to spend money (in foregone wages) to do so in the event that their current policy is more generous (in terms of cost-sharing or covered services) than our comprehensive benefit package. We assume that firms will keep some of the savings from reduced health insurance payments per worker in the form of profits, and share some savings in the form of higher wages and greater employment. Conversely, we also assume that those firms which do not now offer insurance will finance some of their increased payments with lower profits and some with lower wages and reduced employment.

Our best estimate, supported by the analyses of some very prominent economists, is that the net effect of our mandate on jobs is likely to be very small. Consequently, for the purposes of calculating subsidies, we assumed no net job loss or creation, even though Treasury's finding of a substantial tax revenue gain would suggest that the net employment impact is likely to be somewhat positive. The great bulk of the effect of the mandate is thus presumed to flow through wages. The net wage gain grows through time as managed competition constrains premium growth relative to baseline.

Mr. McMILLAN. While we are on the issue of candor, I think while I was out of the room, you may have addressed yourself to the deficit rescission package that we are going to be debating in a little while. As best I can determine from your numbers, the administration's health care proposal includes at least \$20 billion of the \$35 billion in Medicare adjustments that are included in the Penny-Kasich package.

There may be more because, basically, the effects on Medicare parts A and B are essentially the same, in the neighborhood of \$11 billion. The lab copayments are essentially the same, at \$7 million.

The home health care is where there is a question, and there is a significant savings by requiring 20 percent co-pay, which doesn't amount to a lot of money when you really break it down to an individual person, but it does make a lot of difference in the Federal budget.

I would like to ask just one question with respect to that, because you will make the argument that you need to save these savings so that you can use them elsewhere. My argument is with a \$58 billion deficit reduction proposed in your plan, we are not using up any savings, we are just using the same ones a little earlier.

But while we are on that subject, you do add two things. You add long term care, which is billed as a Medicare benefit, but the way you described long-term care, it didn't sound like a Medicare benefit.

Ms. RIVLIN. It is not a Medicare benefit.

Mr. McMILLAN. It is.

Ms. RIVLIN. It is not.

Mr. McMILLAN. But that is the way you are describing it. That is not candor. You are describing a savings for Medicare when you

are going to spend them on the disabled. And with respect to pharmaceuticals, you said that you require 20 percent co-pay on pharmaceuticals, yet you are putting out information about 20 percent co-pay on home health care as if that were a State mandate.

Is the 20 percent co-pay on pharmaceuticals not a mandate?

Ms. RIVLIN. I am sorry. A copayment is a copayment.

Mr. McMILLAN. Not the way the administration is attacking the proposal in the Penny-Kasich plan. Well, let's move on.

Mr. WAXMAN. If the gentleman will yield, that is because of the Penny-Kasich proposal, there is a hold harmless for the co-pay of 100 percent of poverty and below, and specific provisions saying the States will pick that up as part of the Medicaid program.

Mr. McMILLAN. That is the way it has been interpreted. It didn't specifically say that. But I can make that same assumption about most of the \$124 billion or \$65 billion. It is full of mandates to the States.

So I think it is disingenuous to be critical of this plan. If I were the President, I would say, gosh, they are doing 90 percent of what we have been proposing anyway. I think I will just embrace it.

Ms. RIVLIN. There is no question there is very significant overlap between what we are proposing for Medicare and Medicaid and what Penny-Kasich includes. That is the point. We believe that these savings ought to be considered in the context of the whole health reform plan, and ought to be dedicated to health reform.

Mr. McMILLAN. I would do that, but a savings is a savings, and all these funds are fungible, as your proposal so amply demonstrates. So simply moving them forward only means that portion of those savings in the months intervening between the enactment of this rescission package and the enactment of the health care reform bill would be the difference. And that may be \$2 billion. So to bill it as gutting your plan or damaging the economy is disingenuous.

Ms. RIVLIN. We don't know whether health care reform will pass or exactly what form it will take. But we believe the Medicare and Medicaid savings should be part of that discussion. They shouldn't come out ahead of it. There may be trade-offs that we need to make between the different parts of the bill.

The Penny-Kasich amendment, as I understand it, would not make them available for offsets in the health reform bill.

Mr. McMILLAN. But then you make other savings and you raise the \$100 billion worth of taxes which can be refunded into these—whatever your proposed increase in Medicare. They don't match up. You have already said your Medicare savings on long-term care, which are being sold as a trade-off to the senior citizens are not in fact a trade-off to senior citizens. They are going to be refunded to another section of the budget.

Mr. WAXMAN. The gentleman's time has expired.

Mr. Roland.

Mr. ROLAND. Thank you, Ms. Rivlin. It is nice to see you again. Let me ask you a very basic question. The reason the Federal Government has a deficit is because it spends more money than it takes in.

Ms. RIVLIN. That is fair enough.

Mr. ROLAND. Let me ask you about how Medicare contributes to our budget deficit problem. Part A of Medicare is funded by payroll tax; correct?

Ms. RIVLIN. Yes.

Mr. ROLAND. Part B of Medicare, 25 percent is funded by premium, 75 percent comes out of the general fund. Is that correct?

Ms. RIVLIN. Yes, approximately.

Mr. ROLAND. Of course, there is interest that is paid to this trust fund which may also say that money is coming out of the Federal Treasury which would contribute as well to the deficit. But it is not clear to me why, when a payroll tax is paying for part A, which is the largest part, about \$38 billion of \$132 billion that we had last year in Medicare comes from part B, and 25 percent of that is a premium.

Why is it that we are saying that Medicare is contributing to such a large extent to our budget deficit problem?

Ms. RIVLIN. I don't believe that I said that Medicare part A was currently contributing to the deficit. As one looks ahead, one could worry about part A, because the currently projected payroll tax is not sufficient to cover the estimated increase in the costs.

The costs of Medicare and Medicaid and everything else are contributing to the rise in Federal spending, but Medicare part A, by itself, is not—

Mr. ROLAND. Which is the largest part of the Medicare program, right?

Ms. RIVLIN. Right.

Mr. ROLAND. You would concede that part A is not contributing to Federal deficit now because it is funded by payroll tax; is that right?

Ms. RIVLIN. It is not contributing now, but if we don't slow down the growth in cost, we will need a big increase in the payroll tax or some other source of funding. So it is a problem. It may not be a current contributor to the deficit, but it is a contributor to the long-range deficit problem.

Mr. ROLAND. Let me ask you this, going to what Mr. Bliley was going to a little moment ago. If we really don't know exactly what the government expenditures are going to be in the President's plan, I note that you said in your testimony, 14 percent of your Gross Domestic Product goes to health care and by the end of the decade, we could be spending an almost unthinkable 19 percent of Gross Domestic Product on health care.

Since you are going to be using some savings in Medicare to finance the President's plan, would you explain to me how it is going to hold down as a percentage of Gross Domestic Product in the President's plan?

Ms. RIVLIN. The main reason we think that total health care costs as a percent of the Gross Domestic Product will not rise as rapidly under the market restructuring that I have described, that the cost of health care in general will not be rising as rapidly. The decrease in the growth rate will result from the incentives to use low cost plans and to hold down the cost generally.

Mr. ROLAND. Do you really believe we are going to be able to hold down the cost of providing these services by the mechanisms that have been put in place?

Ms. RIVLIN. I do. I believe we can slow the increase. I don't think anybody thinks we are going to turn it around. I do not believe we will ever see health care costs below 14 percent or even 15 or 16 in the United States. But I think we can slow the rate of increase so that it stops rising and levels off.

Mr. ROLAND. Do you believe that to do this purely as a government mechanism is going to really be successful when one considers the increasing cost of care because of an aging population and the technology that we have now, and do you think that we will be able to address biomedical/ethical problems that contribute a great deal to the cost of care?

I think we have to look at this in the entire context and not just from a particular standpoint.

Ms. RIVLIN. So do I. You have named reasons why it is urgent that we get the health care system reformed and change the incentives so we are not wasting resources. We and other advanced nations are up against a very serious problem. We have an aging population and we have rapidly increasing technology that makes it possible to do things that medical care couldn't do before.

So health care costs are rising for a lot of reasons. But we don't need to use these resources inefficiently, and to have unnecessary increases in health care costs. That is what this plan tries to address.

Mr. ROLAND. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Roland.

Mr. Greenwood?

Mr. GREENWOOD. Thank you, Mr. Chairman.

Dr. Rivlin, I would like to discuss the Federal Unemployment Tax Act [FUTA], which imposes, in statute a Federal payroll tax on employers. The manner in which this tax works is of interest because FUTA gives the States the right to set up and run their own State unemployment insurance funds.

If the State unemployment insurance fund meets the Federal statutory requirements, employer tax contributions to the State fund can be taken as almost a total credit against the employers' Federal obligation; in other words, the employer pays the tax to the State rather than to the Federal Government. That obligation is a Federal obligation.

This is of interest because this funding mechanism is very similar to the President's health care reform proposal. The President sets up a mandatory Federal obligation on employers to contribute up to a 7.9 percent payroll tax to alliances which will flow to State agencies or State chartered entities.

With the FUTA tax, there also is a mandatory Federal obligation on employers which can be satisfied by payments to State unemployment insurance funds.

State unemployment insurance funds are listed in the Federal budget as Federal revenues and outlays. If you turn to page 788 of the appendix to the Budget of the U.S. Government, fiscal year 1994, you see that all 50 State employment insurance accounts are on budget. All of the State tax moneys are shown on the Federal budget as revenues and all expenditures are shown as Federal outlays.

Why is this so? It is so, I believe, because the activity is defined as a mandatory obligation under Federal law.

Dr. Rivlin, if State employment trust funds are listed on the Federal budget because of the Federal FUTA tax mandate, does it logically follow that the President's 7.9 percent payroll tax and alliance health care expenditures which will be mandated in Federal law should also be on budget?

Ms. RIVLIN. I think it is important that all of the activities that come under these new alliances be shown somewhere in the Federal budget. It is more complicated than FUTA. The alliances would get revenues from employers, from employees who have a choice of plans, where it is not mandated that they take a particular one, and from the Federal subsidies. We ought to show all of that in great detail in the Federal budget: where that money comes from and where it goes.

I don't think it makes sense to pull out a particular piece of it. It ought all to be there together, so that we can all see it.

Mr. GREENWOOD. If I may interrupt you, you have made one distinction between these two payroll taxes. The distinction you have made is that the health insurance reform proposal is more complicated and involves certain other contributions.

But conceptually, what is the concept that divides the FUTA tax that causes it to be appropriate for it to be on budget, the health care payroll tax to be off budget? What is the concept we use in general to make that distinction?

Ms. RIVLIN. I think it is the way it gets computed or the way it actually happens. The amount that employers will pay will depend on a set of negotiations between the alliance and health plans. These will differ in different parts of the country. And employers will pay 80 percent of the average for their region. But you can't tell in advance what that is going to be.

It is going to depend on negotiation between the alliance and the health plans. And it will depend on what people choose. So this is a structured market for health care which will produce a set of premiums which employers do have to pay, and there can be different ones in different places.

But they will pay 80 percent of the average for their region. But in addition to——

Mr. GREENWOOD. Let me interrupt you again, because my time is so limited. Let's not talk about FUTA and health reform. Let's just talk about a Federal mandate A that requires employers to make contributions and mandate B that requires the same. Just tell me what the conceptual framework is that lets us know, on this issue and future issues, when it needs to be on budget and when it needs to be off budget.

Ms. RIVLIN. I think that really has to be a decision made at the time any particular system is set up. We have not done this kind of thing before. It is somewhat, but not very analogous, to a government sponsored enterprise. It is somewhat, but not completely analogous, to other kinds of mandates that don't appear on the Federal budget. One example is the mandate to provide handicapped access. It is much smaller, but it is a real cost for universities, for instance, and because of its detailed requirements.

But those costs we don't put in the budget. So I think it depends on what kind of an animal we are dealing with. This one is a new kind and we think it should be displayed in a new way.

Mr. GREENWOOD. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you.

Mr. Kreidler?

Mr. KREIDLER. Thank you, Mr. Chairman. One of the issues that has been raised here is the funding of health care reform. And the chairman's questions about the Penny-Kasich amendment and taking the Medicare money out of what would be used to fund health care reform.

If I understand correctly, there are members who are objecting to effectively saying that the proposed reductions in Medicare and Medicaid are concerns to them right now, who think we could take those cuts right now with Penny-Kasich, and then potentially come back and add revenue later on if it was necessary for health care reform.

If I understand them correctly, I think that is what they are saying. I think one of the possibilities here would certainly be to look to a much heavier tax on tobacco products. And I guess I would be interested if there would be support—let's say Penny-Kasich were to pass, Medicare/Medicaid money was not available, would the administration be disposed toward a heavier increase in tobacco products tax in order to fund health care reform?

Ms. RIVLIN. I don't know. That is not a decision that I could make. We would clearly have to look at lots of options. When we came out with the current proposal for a tobacco tax, various options were considered, and that one was chosen.

Mr. KREIDLER. I might, in my own way, encourage the administration to seriously consider that there was a tax rollback initiative in Washington State that was heavily funded by the tobacco industry to try to roll back tax increases on their products, and the interesting part was that even the people in favor of a tax rollback said, go ahead and raise tobacco taxes even higher than they were and certainly don't try to hold them back.

That rollback initiative, by the way, lost. So I just pass that along.

Ms. RIVLIN. Tobacco taxes seem to be one of the few popular taxes, except of course with heavy smokers and tobacco companies.

Mr. KREIDLER. Very true. Also, critics of the President's proposal have complained that we cannot reduce the rate of increase in health care costs as dramatically as we would like to. Do you have any estimate of the additional cost to the Federal Government of adding 1 percentage point to the permitted rate of increase in the premium target for each year?

Ms. RIVLIN. Not with me, but that would be easy to calculate. We can certainly provide that.

Mr. KREIDLER. I would be interested in taking a look at those numbers. Thank you very much.

[The information follows:]

We intend to gauge the sensitivity of the premium targets as well as other aspects of the Health Security Act. To date, however, our modelers and actuaries have been so busy documenting the work they have done in estimating the various components of the Act, as well as preparing for the re-estimation of baselines, and other tasks necessary for the submission of the President's budget consistent with the new eco-

nomics, they have not had time to consider this formally. I can assure you we will request it and we will provide the outcome to you, but I cannot promise a definitive result before January.

Mr. WYDEN [presiding]. The gentleman from Ohio.

Mr. BROWN. Thank you, Mr. Chairman. In following up on that—and I have questions about a couple of other things—what was the process of considering any kind of beer or alcohol tax and rejecting it? Because obviously some of the same issues operate with tobacco tax as with an alcohol tax.

Why was that rejected?

Ms. RIVLIN. We did consider it. We did talk about it, and it was the judgment of the President to stick with the tobacco tax. But it would certainly be within the purview of the Congress to reopen that question.

Mr. BROWN. That was a very direct answer. I already knew that. What were—why was it rejected, other than the decision of the President? Can you make us privy to any of the discussions?

Ms. RIVLIN. No, I really can't. The politics are very different, as we discussed a minute ago. There is very little concerted opposition to increases in tobacco taxes. There would be much broader concern about increases in alcohol taxes, particularly beer and wine.

Mr. BROWN. Let me shift to some questions about the early retiree program as proposed by the President. How do we justify the shift of responsibility for those—for retiree premium payments from large companies and unions in a sense, but from large companies, to the government at a time when we are struggling so much with larger and larger budget cuts? Why was that decision made? How do we justify that?

Ms. RIVLIN. There are some companies with a very heavy burden of commitments to early retirees. And that was thought to be a serious problem for those companies and for some industries. The shift is a contribution that the government could make to easing those burdens.

Mr. BROWN. How do I answer a small businessperson or any voter in my district who would have heard you say that statement when you say there are companies who have large obligations, it is not anybody on the committee's fault or anybody else's fault that those companies for whatever reason have those large obligations.

How do we shift this welfare program—that is the wrong term—why do we shift this program to taxpayers when companies have chosen to bear them for whatever reasons? How do we go home and sell that?

Ms. RIVLIN. Well, I think one has to look at the impact of those costs on the companies and on what might happen if the government didn't help.

Mr. BROWN. What assumptions have you made, if you can share a little bit with us, Dr. Rivlin, about the costs of that program? What do you expect it to cost? What kind of underlying assumptions have you made to calculate that?

Ms. RIVLIN. Let me buck that one to Mr. Thorpe who is going to be your next witness, for a more specific answer, if I may.

Mr. BROWN. I yield my time back. Thank you, Mr. Chairman.

Mr. WYDEN. I thank my colleague.

Dr. Rivlin, let me—I would be happy to recognize the gentleman from North Carolina.

Mr. McMILLAN. I guess the debate has been held one too many times on tobacco. There is a law of diminishing returns. I think at some point it produces less revenue. But I would suggest that if the gentlemen are really serious, they do one of two things. One would be to establish a national tobacco lottery, we will take all the revenue, which is done in other countries—not lottery, but monopoly, which is done in many countries, Mexico or others, or ban cigarettes, tobacco. Then we could have to go get that revenue from someone else. That seems to be where they are headed.

But I wanted to focus a little bit on a different aspect. I have asked this question before to other witnesses, and I would like to ask it of you, Dr. Rivlin, because I think it does relate to this difficulty we are having in defining the credibility of the amount of subsidy without knowing what the total commitment is in terms of mandates on others.

Suppose on July the 1st, of the first year of implementation of the plan, and you are, let's say, the Secretary of the Treasury, you get a call telling you that the Federal Government has reached its capped amount of Federal alliance payments for subsidies for the year, and Congress has categorically refused to raise the caps. You might have a situation somewhat like the S&L problem.

And you are told that although the Federal Government owes an alliance \$10 million in subsidies for low-income families and small business, that you cannot send the money because of the capped entitlement fund having reached its limit for the year.

Now, when you get into that position, what does the director of the regional health care alliance do?

Ms. RIVLIN. I think if we ever got to that situation, which I don't think we would, the alliance would have to make do with less money. But that is a little bit like saying, what would have happened if we had not changed the social security law in 1983, and the Secretary had not been able to send out the checks. I don't think that is going to happen.

We put into the law a mechanism for alerting the Congress in advance when there are estimates that the money is insufficient. Then, the Congress has to look at the whole situation and decide what to do.

Mr. McMILLAN. But you have got a seven-person board and a questionable system to get you there. You have got a seven-person board that is fixing the price, the overall price per capita. Then you are relying upon what you say is competition to bringing costs down. But you are doing things to diminish that competition.

I think you are creating a situation in which inevitably the executive of a State alliance is going to be in that position.

Ms. RIVLIN. Oh, I don't agree. I think we are creating conditions under which competition can work, and in which consumers have a substantial financial incentive to move to lower cost plans. If they don't, we are capping the rate of growth of premiums. So all of those things safeguard the system against running out of money.

Mr. McMILLAN. And I have run out of time. Thank you.

Mr. WYDEN. I thank my colleague.

Dr. Rivlin, let me stay with activities in the private sector for a moment. Again, as somebody who feels that the President and Mrs. Clinton are headed in the right direction, I want it understood that I just feel very strongly that I and others are going to have to see some of the distributional effects of what is going on in the private sector. And I look forward—

Ms. RIVLIN. I think so too, and we will talk about those.

Mr. WYDEN. Let me ask you about something else. I am certain you all have studied the private sector, and that is there has been the discussion of negatives of what goes on in the private sector. But I gather you all have also looked to some of the quantifiable positive effects on employers and employees as a result of the cost containment effort and the private sector focus.

Could you take us through that, just briefly?

Ms. RIVLIN. Yes. We believe that especially over time, as the costs rise less rapidly, that most employers will find themselves paying less than they would otherwise have paid. Now, what does that mean for companies? It means they either have more profits or, more likely, they begin paying higher wages, because most economists think that the effect of higher fringe benefits like health care costs is lower cash wages.

And when it is less costly to provide those benefits, I think wages will be competed up.

Mr. WYDEN. I would urge you all to share that distributional analysis as well, because that would be my sense, is that a strong cost containment strategy in the private sector, apart from what all—what we have heard on the negative side has been, we clearly have positive effects on the private sector as well.

And to the extent you all can share that with us quickly—

Ms. RIVLIN. I think that is definitely right, and that underlies the estimates of what I believe on the chart we called "Other Revenue Effects." Some of that will show up, whether it is increased profits or increased wages, in increased Federal revenues.

Mr. WAXMAN. Thank you, Mr. Wyden.

We have had a second round by Mr. McMillan and Mr. Wyden. I am going to forego a second round, because I know Dr. Rivlin has a meeting.

Do any members have more questions they want to ask?

Mr. Greenwood.

Mr. GREENWOOD. Thank you, Mr. Chairman.

Dr. Rivlin, I would like you to turn to page 978 of the Health Security Act. Please look at section 6002-C. Section C provides the update for the average national per capita spending for the years 1994 through 1996. During these 3 years, there is no premium cap, global budget, nor other price controls.

Consequently, health care spending will increase at the level determined by the market. Over the last 5 years, that rate has been approximately 10 percent annually. Compounded for the years between 1994 and 1996, that would give us a cumulative update of roughly 33 percent by the year 1996.

Consequently, actual spending should increase by 33 percent over this time frame. Now, let me read lines 11 and 12 on page 979. "The total cumulative update under this subsection shall not exceed 15 percent."

Now, what is going on here? Let me try to explain this. Simply put, instead of using actual expenditures for the calculation of the baseline per capita amount for the initiation of the act, the bill is mandating an across-the-board reduction in the baseline.

In the real world, expenditures will have increased by 33 percent over the 1994 to 1996 period. In the world of this bill, expenditures are allowed to increase only 15 percent over this time frame. This is a huge difference since these percentages would be applied to over \$600 to \$700 billion. This could lead to a reduction in the baseline per capita amount which is the foundation of the premium cap of approximately \$100 to \$150 billion.

This is confirmed by the chief actuary in HCFA who stated, "The actuarially determined premiums for the first year of reform, 1996, are reduced by nearly 25 percent by the global budget. The associated Federal subsidies are reduced by more than 40 percent by the impact of the global budget."

In your book, "Reviving the American Dream," you state that one of your assumptions when analyzing policy is, "a bias against magic wands and painless solutions. Everybody looks for ways to accomplish goals without effort."

Wouldn't you characterize this as a magic wand? These two lines of legislation, which constitute only 11 words, are single-handedly generating the vast majority of the bill's up-front savings. I would like your comment on that.

Ms. RIVLIN. No, I wouldn't characterize it as a magic wand. You have thrown a lot of numbers around, but I would like to sit down with you and go through that. I don't think the 33 percent is an accurate interpretation. But I think——

Mr. GREENWOOD. Why is that?

Ms. RIVLIN. We need to go through it line by line and see if we can't——

Mr. GREENWOOD. Tell me why——

Ms. RIVLIN [continuing]. Come to a mutual understanding——

Mr. GREENWOOD. Tell me why the 33 percent is unrealistic.

Ms. RIVLIN. Just because it is not going to be unrestrained during this period, with the assumptions of the plan in place.

Mr. GREENWOOD. And the restraints, what would the new restraints be?

Ms. RIVLIN. Well——

Mr. GREENWOOD. There will be new restraints. Which restraints will they be?

Ms. RIVLIN. We believe that competitive forces will hold this rate of increase down, and that we are——

Mr. GREENWOOD. These are new competitive forces that don't exist today?

Ms. RIVLIN. Yes.

Mr. GREENWOOD. And which are they?

Ms. RIVLIN. Absolutely. We are changing the incentives a great deal. Right now, hardly anybody has an incentive to hold down the cost of health care.

Mr. GREENWOOD. You are telling us today that in the years 1994 through 1996, new competitive market forces created by the passage of this bill will more than cut in half our anticipated rate of growth in health care costs?

Ms. RIVLIN. I want to sit down with you and go through this calculation, because I have not heard this before and I don't know exactly what you are talking about. So I think we should sit down and go through it in more detail.

Mr. GREENWOOD. Indeed, I think we should. Thank you.

[The following information was received:]

You asked a very specific question about the application of our premium caps in the form of our "update factor" limit in the early stages of our reform. The intention of the "update factor" is simply to extend the baseline for 2 years to provide an updated baseline for future cost containment. The "update factor" is not intended to accomplish any cost containment until the premium caps become effective beginning in 1996.

As you noted, the draft bill extended the baseline for 3 years, including 1996. It was never intended to include 1996, and H.R. 3600 does not include 1996 in this provision. The effect of this change reflects the original policy, which was simply to update the baseline number, not to impose cost containment in the interim years.

The "update factor" in the bill is intended to reflect the most accurate projection of health care spending for 1994 and 1995. Obviously this projection will vary based on our estimates of future health care spending. While it is important that the legislation contain a specific number as an update factor, we need to make this number as accurate as we can. Our current estimate of private health care spending increase for the 2 years is 19.4 percent, and our cost and savings projections reflect this figure. H.R. 3600 should reflect 19.4 percent as well.

Mr. WAXMAN. Thank you, Mr. Greenwood.

Do any other members want to ask other questions?

Mr. Cooper?

Mr. COOPER. Thank you, Mr. Chairman.

I would just like to ask Ms. Rivlin, it is my understanding there is an administration document that indicates exactly how competition has a chance of achieving the budget targets without the imposition of premium caps. I would hope that you could share that document with the committee so that we could have a better understanding of how the premium caps are in fact a backstop, to use administration terminology, even though they seem to click in in the very first year of operation.

Do you have at your fingertips any preliminary indication—

Ms. RIVLIN. I don't have such a document. We are very happy to share the evidence on which we are relying with you, which is basically the managed competition literature with which you are very familiar. There is considerable evidence that managed competition can slow the rate of growth of costs.

Mr. COOPER. Since you are a former CBO director, can you predict for us whether CBO will agree?

Ms. RIVLIN. No, I can't.

Mr. COOPER. Maybe I better stop there. I appreciate it, Mr. Chairman.

[The following information was received:]

This very good question cuts to the heart of a rather subtle feature of our plan, but one we think makes a lot of sense. The caps do indeed "click in" in the very first year, but the "shock" is not likely to be as great as one might imagine. The lower trajectory of target premium growth does start the first year, but the health plans in a particular State don't have to hit the target until the first year their alliance is up and running. This means that they could continue with baseline growth until forming their alliance. Of course, in anticipation of the incentives for cost-effective care that managed competition will provide, we expect most successful plans to form networks and reorganize their case-management systems in such a way that there will be savings against the baseline almost immediately. It is precisely this anticipatory reorganization that makes us think the caps will be backstops even in year one. Plans will have the leverage necessary to renegotiate contracts with pro-

viders, unlike the case today, because providers will also face a competitive and uncertain future just over the horizon.

In addition, the longer a State waits to form alliances, the farther the "drop" from baseline to the target trajectory its plans will have to make. This increasingly intense incentive should generate political pressure within a State and encourage more States to form alliances sooner rather than later.

Mr. WAXMAN. Dr. Rivlin, we thank you very much for your time with us. You have been very, very helpful to us in helping understand the financing and how all this fits together. We thank you for being here.

We have a vote on the House Floor. I think there may be two votes. I think we should recess and come back at 1:15 p.m. So we will reconvene here at 1:15 p.m.

[Brief recess.]

Mr. WAXMAN. The meeting of the subcommittee will come to order.

Our next witness is Kenneth Thorpe, Deputy Assistant Secretary for Health Policy. Dr. Thorpe supervised the development of estimates for the President's health reform proposal. Prior to joining the Department of Health and Human Services he held faculty positions at Harvard University, Columbia University and the University of North Carolina.

Dr. Thorpe most recently appeared before this subcommittee on November 8th at our hearing on the cost containment features of the President's plan.

Dr. Thorpe, we want to welcome you back to our subcommittee. You did such a good job we wanted you back for another performance. If you do another good job today we will want you back again. We are going to make your prepared statement part of the record in full. We would like to ask you to limit your oral presentation to 5 minutes.

STATEMENT OF KENNETH THORPE, DEPUTY ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. THORPE. Thank you, Mr. Chairman. It is a pleasure to be back with you today.

I am pleased to have the opportunity to discuss with you the process by which the financing and premiums underlying the President's health care reform proposal were modeled.

Estimates of premium costs, national health spending and government program costs under health care reform have been necessary in the decisions leading to a health care reform bill. During the policy development process, exploration of alternative policies required estimates of the cost impacts of each possible variation. Specific areas included analyses of premium caps, the impacts on businesses of mandated employer payments, the effects on households of mandatory purchase of coverage, and the budgetary effects of discount schedules.

The development of estimates of this type is obviously a complex task. Numerous data sources offer information on current spending for medical services by a variety of payers and for a wide range of population subgroups. However, there is no single data set which captures all spending for all services through all sources of funding.

One of our major tasks has been to develop an estimated cost of providing our comprehensive set of health care benefits to the entire population eligible for coverage. This includes the uninsured, those getting coverage through small businesses, large businesses, those who directly purchase insurance, the Medicaid population and individuals who during the year are uninsured and who often-times have health insurance from any of the sources that I have mentioned above. Developing such an estimate requires data representing the entire population. The starting point for our estimates is the 1987 National Medical Expenditure Survey. The National Medical Expenditure Survey offers the best characterization of national spending.

In addition to the NMES, we have relied on the National Health Accounts, the best available data on total national spending by type and source of service. Our approach to estimating premiums could differ from estimates produced by health insurers and other benefit consultants. Our starting point is to develop a premium estimate for all Americans under reform. That is why one needs to use a nationally representative set of data.

In contrast, other premium estimates of our package will rely on a different starting point: their own claims experience with their clients. Using these approaches one could generate literally hundreds of different premium estimates, one from each existing health insurance company and employee benefit consulting firm. Each would develop a different premium estimate based on the special characteristics of the population they insure.

As a result, these approaches, while providing consistent estimates of their own population, would not produce a nationally representative estimate of the cost of providing our package to all eligible Americans.

I would like to spend a few minutes talking about the specifics of how we arrived at our premium estimates. I have much more detail on the methodology in my written statement.

First the process. We had two agencies independently develop premium estimates, the Health Care Financing Administration Office of the Actuary, and the Agency for Health Care Policy and Research, both within the Department of Health and Human Services. Both sets of estimates were reviewed by an outside auditing group of consulting actuaries and presidents of private actuarial consulting firms. These firms primarily were interested in looking at our approach and methodology deriving these estimates. We ended up using the HCFA estimates in our costs largely because they were higher, and we thought, therefore, more conservative.

Data. Primarily, we used three sorts of data in our estimates. First, the Current Population Survey; second the National Medical Expenditure Survey; third, and perhaps most importantly, the National Health Accounts data.

Let me briefly describe these in five or six steps that we undertook.

First, we calculated the expenditures for individuals and families under the current system. The trick is to make sure that one has a data set in the way of estimating that this is nationally representative of all populations at issue. For the currently uninsured this was accomplished through statistically matching the unin-

sured to the currently insured having similar sociodemographic characteristics.

Second, determination of whether individuals and families were in regional alliances or in corporate alliances. We developed separate premium estimates for each. The premium estimates that you see in front of you are those that exist for individuals receiving coverage through the regional alliances including individuals who work for firms under 5,000.

To assure conservative estimates of our discounts all family units in which one full-time worker was employed in a large firm and one full-time worker in a small firm were each assigned to the regional alliance.

A third step: We adjusted our expenditures to reflect the benefits covered in the comprehensive benefit package, and we looked at 10 classes of expenditures. We adjusted these for deductibles, coinsurance and cost-sharing limits. In addition, individuals were matched to make sure that we come up with the most consistent estimates based on their health status, age, gender, disability status, income and insurance.

Fourth, we adjusted expenditures for higher demand for people who are currently uninsured due to the fact that they now receive insurance. We matched these individuals according to the characteristics that I just talked about.

Fifth, we reduced the premiums to reflect the Act's elimination of cost shifting from the uninsured by eliminating uncompensated—by virtually eliminating uncompensated care from the premiums. In addition, the Act will specify that currently uninsured individuals would be paid at a cost that is an average cost of providing services. Both those adjustments are critical to our premium estimates.

With respect to discounts, there are several types of discounts targeted at different payers. There are two employer discounts, one directed to all firms in the regional alliance and one directed at small firms with less than 75 employees. Our major models were similar in how they estimated most of the components.

Let me spend a couple minutes just to walk through where these subsidies and discounts go.

As Dr. Rivlin discussed, over the 1995 to 2000 time period we estimate about \$349 billion in gross subsidies. They go to individuals in the following sequence:

First, about 29 percent of the discounts are for employer payments. Of those, nearly 75 percent of the discounts go to firms with 25 or fewer workers so we have tailored this plan to make sure that the discounts on the employer side are directed towards low-wage small firms.

Second, 53 percent of the discounts are for households. Most of these payments are regular payments for families with non-workers or self-employed workers. About 3 percent of the discounts go for early retirees, about \$11.6 billion between the year 1998 and the year 2000. The remaining discounts are a cushion for our premium estimates. This cushion is 15 percent or \$44 billion over the time period.

Finally, we include about \$9 billion in discounts to cover out-of-pocket payments for the poor.

Dr. Rivlin talked a little bit about the subsidy cushion. Let me say that it is there to serve several purposes: First, to cover the additional cost of potentially induced retirement due to our early retiree policy; second, it is there to cover any costs with respect to outsourcing, if you will, of individuals from higher-wage firms to lower-wage firms. Third, we did several simulations as a contingency to see what would happen to our discounts if we had a substantial economic downturn.

In particular, we had looked at a change in the employment rate or unemployment rate of 2 percent, meaning we looked at how our discounts would change if the unemployment rate increased by 2 percentage points, a substantial increase in the unemployment rate. That would increase our discounts by \$4 billion per year. If you add each of these three contingencies together they are still well within our 15 percent cushion that we built into our discount schedule.

Mr. WAXMAN. Dr. Thorpe, the rest of that statement will be in the record.

[Testimony resumes on p. 66.]

[The prepared statement of Mr. Thorpe follows:]

STATEMENT OF

KENNETH THORPE, PH.D.

DEPUTY ASSISTANT SECRETARY OF HEALTH AND HUMAN SERVICES

Good morning. I am pleased to have the opportunity to discuss with you this morning the process by which financing and premiums underlying the President's health care reform proposal were modeled.

Because of the high standard she sets, it is always a pleasure to listen to but a task to follow Alice Rivlin.

I. Background

Estimates of premium costs, national health spending, and government program costs under health care reform have been necessary in the decisions leading to a health care reform bill. During the policy development process, exploration of alternative policies required estimates of the cost impacts of each possible variation. Specific areas included analyses of premium caps, the impacts on businesses of mandated employer payments, the effects on households of mandatory purchase of coverage, and the budgetary effects of the discount schedules.

The development of estimates of this type is obviously a complex task. Numerous data sources offer information on current spending for medical services by a variety of payers and for a wide range of population subgroups, but there is no single data set which captures all spending for all services through all sources of funding.

Federal surveys, especially the 1987 National Medical Expenditure Survey, offer the best characterizations of national spending. The National Health Accounts generated by the Health Care Financing Administration (HCFA) summarize the best available data on total national spending by type of service and source of fund. Producing estimated spending under health reform, however, requires developing a comprehensive baseline summary for literally hundreds of affected sub-populations, and estimating the future spending patterns associated with the reform.

Estimates of future costs of reform are primarily derived through modeling transfers of current spending among the various channels of payment. Estimating the impacts of changing primary payers is relatively straightforward, given a baseline of national health spending. More difficult is estimating the net impacts of fee upgrades and paying for uncompensated care, since reimbursement levels will be set to achieve some recapture of these increased outlays for current services. Also difficult is estimating the induced spending attributable to new or enriched insurance coverage. Because of lack of data, estimates must be based on imperfectly representative experiences of government and private insurers as well as the results of academic studies of the demand for medical care.

Due to this complexity, multiple methodologies, data sources, and models were needed to produce estimates of premiums, discounts, and the overall effects of reform options. Major contributors included HCFA's Office of the Actuary (OAct), the Agency for Health Care Policy and Research (AHCPR), the Treasury Department, and other government agencies. Numerous consultants assisted in the process, with major modeling contributions provided by the Urban Institute.

II. Description of the Major Models

A. The Urban Institute's Transfer Income Model (TRIM2):

The Urban Institute has developed a microsimulation model called the Transfer Income Model (TRIM2). This model has been used to analyze the financing of national health care reform plans, and has particularly focused on the distributional effects of such proposals. TRIM2 is based upon the March 1992 Current Population Survey (CPS) and combines data from a number of other sources in order to provide a complete basis for assessing acute

care health spending by the non-elderly in the U.S. population.¹ The complete model has been aged to 1994, and all results are presented in 1994 dollars.

The TRIM2 model simulates the employer group health insurance system, non-group or individually purchased health insurance, out-of-pocket spending, and the Medicaid program. The model assigns spending under these programs/systems at the individual and family levels and adjusts for regional variation in premium levels. It is then possible to assess the distributional effects of the financing of the current health care system. Detailed tax calculations allow the analysts to examine health spending on an after-tax basis and to calculate the after-tax value of employment-based health benefits. TRIM2 can also be used to simulate the distribution of health spending and health care financing burdens under alternative assumptions about how insurance would be provided and financed.

B. The Health Care Financing Administration's Special Policy Analysis Model:

HCFA's Special Policy Analysis Model database is also based upon the March 1992 Current Population Survey (CPS). The March 1992 CPS acts as the host file, with each person on it being statistically matched to a person on the 1987 National Medical Expenditure Survey (NMES). Health expenditures and utilization from the NMES person record are then linked to the CPS record, and the entire data set is controlled to be consistent with 1994 National Health Account data. The parameters used in the linking the NMES file to the CPS were disability status, age and gender, family income, and insurance class of the person.

¹Historically, TRIM2 has been used to analyze current and alternative tax and transfer programs.

Once each CPS person was linked to a NMES record, expenditure data by service (hospital inpatient, hospital outpatient, etc.) and source of payment (out-of-pocket, private insurance, Medicare, Medicaid, etc.) were attached. This file was then aged to 1994 through two steps. First, the 1992 CPS population was weighted to sum to the 1994 Social Security Administration (SSA) non-institutionalized population (about 20 million more than Census estimates). This was done by age (20 age groups), gender and marital status.

Second, the total national health expenditures by this SSA-weighted CPS population (the Special Policy Analysis Model population) were then "benchmarked" by service category, channel of payment, and age category to the aggregate totals in the projected 1994 National Health Accounts.

C. The Agency for Health Care Policy and Research's Simulation Model (AHSIM):

AHSIM is based on AHCPR's 1987 National Medical Expenditure Survey (NMES-2), which is the most recent national effort to collect comprehensive, person-level profiles of health care use, spending, and insurance coverage. AHSIM currently is designed only to analyze the non-elderly (under 65), noninstitutionalized civilian population residing in the United States. Although the NMES-2 data were collected in 1987, demographic variables have been aged forward by reweighting individual records. New weights take into account changes in the distribution of the population by age, race, sex, insurance status, and poverty status observed between the November 1987 and March 1992 Current Population Surveys. Additional demographic aging is based on Census projections of the population by age, race, and sex beyond 1992. Real growth in service-specific health expenditures and insurance premiums have been incorporated through adjustments based on the appropriate rates of changes in HCFA's National Health Accounts and its projections.

AHSIM draws primarily on the NMES-2 Household Survey and its two derivative components, the Health Insurance Plan Survey (HIPS) and the Medical Provider Survey. The Household Survey sample, roughly 35,000 individuals and 14,000 households, is representative of the civilian noninstitutionalized population of the United States in 1987. completed all rounds of data collection. The Medical Provider Survey obtained information directly from the physicians, hospitals, and other providers used by a portion of the household sample. These data were used to edit and supplement household survey data describing use of and spending on health services. HIPS data were collected from employers, unions, and insurers and include premiums paid by all sources and specific provisions of baseline private insurance coverage. They also provide information about the organizations offering insurance coverage and include in the case of employers, firm and establishment size, industry, and location.

Other data sources were incorporated when needed for specific purposes. For example, survey data from the Health Insurance Association of America were used to project market shares for fee-for-service, HMO, and preferred provider health plans by region. Annual survey data from the American Hospital Association were used to determine the allocation of hospital spending between inpatient and outpatient services and to identify local areas in which at least one HMO is operating. County Business Patterns data were used to impute average payroll for employers, using a statistical match based on industry, location, and firm size. The Internal Revenue Service's Statistics of Income data were used to expand NMES-2 income data and to calibrate the AHSIM tax module.

III. Premium Estimation Under Reform

Both HCFA and AHCPR estimated the cost of health insurance premiums under reform. Their estimates are in 1994 dollars and reflect the benefits included in the comprehensive benefit

package. Competing approaches were intentionally used to enhance confidence in the estimating process, and to permit selection of the more conservative estimate where variation in modeling outcome was identified.

A. Health Care Financing Administration:

The first step in HCFA's simulation process was to determine each individual's insurance status. The modelers used CPS indicators for this, and considered a person to be insured if he/she was covered by employer-sponsored insurance, other private insurance, CHAMPUS, Medicare, or Medicaid. HCFA then adjusted health expenditures to reflect the coverage offered through the regional alliance plan. That coverage is for hospital care, physician and other professional services, prescription drugs, and durable medical equipment other than vision and hearing products. Therefore, the analysts excluded all other National Health Accounts expenditure categories.

The cost of coverage for mental health, dental, and preventive care in the standard benefit package was estimated separately, from aggregate data, and added in at the end of the process. Once expenses were adjusted for coverage differences, the modelers applied the fee-for-service plan deductibles, coinsurance, and cost-sharing limits to each person covered through the regional alliance.

An insurance-induced demand adjustment was applied to all those enrolled in the regional alliance. The basis for the induced demand was the difference between out-of-pocket spending under current law and that determined by the reform simulation already described. The induction factor varied by type of service. Post-induction spending is equal to the expenditures calculated previously plus (or minus) induced spending.

Following these steps, HCFA imputed expenses to currently uninsured people. Existing patterns of use for the uninsured person were discarded, because those patterns are influenced by the absence of insurance. An imputation file was created for each service covered under the regional alliance. To create the file, insured people were divided into groups according to gender, four age classes, and three poverty status classes. Expenditures were tabulated for each group to determine: (a) the proportion that had no expenditure and (b) mean expenditures and use for each decile of the user distribution. Expenses were imputed for uninsured persons using these imputation files.

A final simulation was performed to model which people were covered by the alliances. People were divided between the corporate alliance and the regional alliance according to the worker status of the adults in the insurance family, and were assigned to one of three policies: individuals (and couples with no dependents), one adult plus dependents, and two adults plus dependents. Lastly, analysts applied the family limits on out-of-pocket spending to determine the plan benefits and copayments.

In order to generate an upper-bound subsidy estimate, whenever a two-earner couple had one worker in a large firm (5,000 or more workers) and one in a firm that would be covered through a regional alliance, the couple was assumed to choose coverage in the regional alliance. This maximizes the potential discount costs given that no government discounts are available through the corporate alliances.

After plan benefits had been determined, premiums were calculated for each of the policy and alliance types. An offset was applied to expenses to reflect current-law cost-shifting attributable to uncompensated care. Currently, private sector premiums are higher than they would be if there were no uncompensated care in the system since providers pass these

unpaid costs on to insured, paying patients. Under reform, all persons will be insured; consequently, baseline premiums should be reduced to reflect the elimination of non-payers from the system. A load factor was applied to the benefit cost per policy. The load factor was 15 percent for the regional alliance.

B. Agency for Health Care Policy and Research:

AHCPR's method of generating premium estimates has seven steps. First, following conventions in health economics, AHSIM estimates a two-part model of expenditures for each service. The unit of observation is the person. The first equation in each service's set of two equations estimates the probability of using the service at all as a function of demographic, income, insurance, employment, and health status measures from the 1987 NMES-2. The second equation estimates annual expenditures on the service for all users of the service, as a function of the same explanatory variables. Combining the result of these equations (i.e., multiplying the probability of use times the coefficients in the second equation) yields an equation that predicts expenditures for each type of person. Predicted expenditures are aged to 1994.

Health expenditures for each person are then predicted for each of the ten services included in the AHSIM Model using this system of equations. Predictions for both the probability and the level (given any use) of an expense were made for each person based on these regressions. The procedure assigns the same expected values to people with private insurance and similar personal characteristics, based on a hypothetical "average" insurance policy. Expected values are modified to take into account specific plan provisions using information from the RAND National Health Insurance Experiment about the effects of such provisions. Reform expenditures are imputed to all people in the model using a stochastic process that maintains observed

correlations in expenditures across service types while controlling for the demographic characteristics and health status of individual NMES-2 respondents.

Every individual included in the AHSIM Model actually had three types of reform expenditures assigned to them, indicating their (assumed) behavior under fee-for-service (FFS), managed care (HMO), and preferred provider (PPO) insurance arrangements. Expenses for benefits paid, cost-sharing and noncovered services were calculated separately for each type of plan by applying claims-processing logic to the appropriate estimated expenditure. Premiums for each type of insurance plan were computed on the basis of average benefits paid per insurance policy plus an administrative load set at a percent of benefits paid. In this way, each person was taken into account in computing initial premium levels. Premiums were adjusted for current regional variations in prices.

Individual choice of health plans under reform was modelled by randomly assigning health insurance units to one of the three types of plans (FFS, HMO, PPO) described above. The assumed probabilities of selecting particular plans were based primarily upon market shares observed by the Health Insurance Association of America (HIAA) in their annual surveys, trended forward to 1994. These estimates were modified by assuming a 10 percent reduction in FFS under reform as a result of managed competition. Market shares were allowed to vary on the basis of region, urban/rural location, and the availability of discounts for out-of-pocket expenses and premiums.

Two passes through the data are made to compute the final set of premiums. The first pass implements decision rules regarding the distribution of premium payments under reform. It also computes the cost of noncovered services and cost-sharing requirements borne by individual households. Based on these

calculations, the model determines the extent to which a household's direct costs will be offset by supplemental insurance and out-of-pocket discounts. In the second pass through the data, expenditures are increased to reflect additional spending induced by supplemental insurance and out-of-pocket discounts. Insurance premiums are then adjusted to reflect these higher expenditures.

IV. Discount Estimates

The President's health care reform proposal includes a number of different discounts, targeted at different payers. There are two employer discounts: one directed at all firms in the regional alliance, and one directed at small firms with less than 75 employees. There is a discount for the family share (20 percent of the actuarial value) of premiums and for out-of-pocket payments for both working and nonworking low income families. There is also a discount for the 80 percent premium share for those families who do not have at least one full time worker (or equivalent), including early retirees. The major models are similar in how they estimate most components.

A. Employer Discounts:

The general firm discount consists of a 7.9 percent of payroll cap on all firm premiums, regardless of firm size, provided the employer is in the regional alliance. If the cost of providing 80 percent of the adjusted premium per worker exceeds 7.9 percent of firm payroll, the federal discount is equal to the difference between the two amounts.

The small firm discount schedule (see Appendix A) provides lower payroll caps (below 7.9 percent) for firms with less than 75 employees and average pay below \$24,000 per year.

B. Discounts for the Self-Employed.

Those individuals who are self-employed are obligated to make a contribution to the alliances based upon the same schedule

used to determine small business payments. So, for example, a self-employed person who is also employed by a firm and who is working a full-time, full-year job for wages or salary has no further obligation with regard to the 80 percent/employer share. Similarly, an individual who works full time for wages for 8 months and then quits that job and becomes self-employed would only be obligated up to a maximum of 4 months of the 80 percent of the adjusted per worker premium for his/her health insurance unit type.

C. Discounts to Low Income Families.

Low income workers and non-workers (those with family income less than 150 percent of poverty²) are eligible for government discounts to assist in the payment of the family share of the premium and to assist with family out-of-pocket payments (co-insurance and deductibles). Families below poverty do not pay more than 3 percent of income for their family premium share contribution; those with income below \$1000 have no premium contribution. Families at or above 150 percent of poverty are responsible for paying the full 20 percent share, or 3.9 percent of family income up to \$40,000, whichever is less. The government discount is equal to 20 percent of the actuarial premium for the health insurance unit type, less the calculated family contribution. For purposes of this calculation, family income is equal to adjusted gross income less unemployment compensation plus non-taxable interest income.

An out-of-pocket spending discount is available for those families below 150 percent of poverty who live in an area that does not provide access to a low cost sharing (HMO) plan. In

²The family size specific poverty guidelines used are:
 single -- family size is 1
 couple -- family size is 2
 single parent family -- family size is 3
 dual parent family -- family size is 4.

such cases, the family is only obligated to pay the cost sharing that would be required if the family had actually enrolled in an HMO (i.e., \$10 copayment for outpatient services); the remainder is financed by the government.

Families without at least one full time worker or equivalent³ may be required to pay at least some portion of the 80 percent adjusted premium share that is covered for workers through their employers. Families with non-wage income below 250 percent of poverty are eligible for some subsidization of this obligation.

Families with non-wage income lower than the poverty level do not pay more than 6.4 percent of their non-wage income for this portion of the premium, and families with less than \$1000 in non-wage income have no required contribution towards this portion of the premium. Non-wage income is calculated as Adjusted Gross Income (AGI) less wages and salaries less unemployment compensation and less self-employed income.⁴ Income in this category includes: rents and royalties, interest (including non-taxable interest income), dividends, alimony, capital gains/losses, the taxable portion of social security, partnerships, and trusts. Aside from these items, other categories of excluded income are: welfare payments, VA benefits, worker's compensation, child support income, inherited money, and proceeds from life insurance.

³Two examples of families with a "full time worker equivalent" are:

1. each spouse works half time for the full year;
2. one spouse works full time for 8 months and the other works full time for 4 months.

⁴The actual legislation excludes wages and salaries up to \$60,000 per year. Wages and salaries in excess of this amount count towards this calculation. The \$60,000 exclusion cap was not modelled, making the subsidy estimates somewhat over-stated.

D. Retiree Discounts.

Families with retirees⁵ are eligible for a special discount. When fully phased in, government discounts cover the full 80 percent/employer share for non-working retirees. Government discounts are offset to some extent by the employers of retirees who work part time and the employers of working spouses. For example, a 58 year old man who is working half time will have half of his employer contributions made by his employer and half of his contributions will be made by the federal government. No government discount is necessary when a retiree has a full time working spouse, as the spouse's employer's contributions will fulfill the coverage responsibility. However, if a retiree is married to a non-worker, the government discount will cover the couple (or family).

E. Estimates of Distributional Impact of Discounts

TRIM: In the TRIM2 model, employer obligations (either 80 percent of the adjusted premium for each worker or a percent of total payroll) are calculated for each worker; there are no firms per se on the CPS, although each worker has employer information associated with them. TRIM2 assigns firm average payroll information from the County Business Patterns (CBP) data to each worker, using a statistical matching procedure that relies on industry (the 3-digit SIC codes), state of residence, and establishment size. In addition, an average firm premium is imputed to each worker.

The employer's payment is proxied by the comparison of average pay times the appropriate percentage cap (3.5 percent to 7.9 percent) to 80 percent of the average firm premium. If the

⁵The policy defines retirees as those nonworkers who have fulfilled a requirement of a minimum number of working quarters and who are between the ages of 55 and 64, inclusive. However, the models being used to simulate the cost of the plan do not have data on quarters worked. Consequently, all individuals 55 to 64, who are not working or work part time or part year, are modelled as being eligible for the special retiree subsidy.

80 percent of the average firm premium is less than capped average pay, the employer would pay 80 percent of the correct adjusted premium for each worker. If, on the other hand, capped average pay is less than 80 percent of the average firm premium, the employer would contribute 7.9 percent (or the appropriate percentage less than 7.9 percent) of total payroll to the alliance.

HCFA/AHSIM: In the Special Policy Analysis Model and AHSIM models, the basic calculations of employer discounts are similar to those in TRIM2. Similar approaches are used to estimate other discounts.

V. National Spending Impacts

The change in spending produced by health reform can be summarized in terms of the impacts on businesses, households, and governments. Present business spending is here limited to employer contributions for employer-sponsored health insurance and for active workers and retirees. Under reform, employers are required to pay 80 percent of the average worker premium in their area (net of discounts) for most workers. Those employers currently paying more than the required employer contribution percentage, or buying richer coverage (e.g., lower cost-sharing) are assumed to continue to pay more than the required minimum.

The calculations of changes in business outlays are similar in TRIM2 and the Special Policy Analysis Model. If an employer currently pays more than 80 percent of premiums, TRIM2 increases employer spending under reform to match the proportion contributed by the employer currently, as long as this does not exceed current spending. If maintenance of the current proportion would exceed current spending, it is assumed that employers increase their spending only to the point of current spending. Worker contributions are reduced accordingly. This first part of supplementation is then increased to add the cost

for enhancing the richness of coverage up to the current level of plan richness associated with each currently insured worker. The cost of matching the current richness of benefits is paid by the employer and the worker in proportion to current premium contributions.

In the Special Policy Analysis Model, additional coverage is assumed wherever current payments are better for the family than modeled future payments under the mandated benefit package. Supplementation amounts are accumulated equal to the difference between current and required benefits. Employer contributions are assumed to cover the supplement, although employer payments for the required coverage are held to the mandated minimum.

The AHSIM Model assumes that both employers and households attempt to hold their spending on health insurance constant from baseline to reform. To the extent that baseline spending on employer-sponsored insurance exceeds expenditures required under reform, employers are first assumed to buy down their employees' required contributions. If baseline spending exceeds reform requirements for either households or employers after taking this transfer into account, the AHSIM model then allows both households and employers to buy supplemental insurance. For each health insurance unit in AHSIM, the actuarial value of supplemental insurance purchased under reform cannot exceed baseline levels. The total amount of supplemental insurance is also limited by the level of potential out-of-pocket expenses (cost-sharing plus noncovered services) under reform. Supplemental insurance is also assumed to carry a higher administrative load than basic health plans, 25 percent in most recent simulations. Any employer excess that remains after buying supplemental insurance is assumed to increase other tax-preferred fringe benefits.

Household spending is defined to be the employee contributions for employer-sponsored health insurance, direct premiums for non-group coverage (under the current system) or direct purchase of alliance coverage (under reform), and cost-sharing payments. In the baseline, the employee contributions are defined to include employee payments irrespective of tax status; pre-tax employee contributions are counted as employee payments despite IRS treatment of such sums as employer contributions. To the extent supplementation implies higher business payments, household spending is reduced by like amounts. Total changes in cost-sharing are calculated as the net of reduced payments due to new and enriched coverage, against increased cost-sharing attributable to required purchase of insurance leading to increased utilization and some personal payments (rather than reliance on uncompensated care mechanisms).

Government spending changes reflect transfers between the Federal government and other levels of government, as well as increased Federal responsibilities (particularly in arranging discounts for low-wage firms). Baseline Federal spending is primarily Medicaid and Medicare. Under reform, Medicaid non-cash populations move into alliance plans, with some direct business payments. Similarly, more Medicare recipients fall under working aged rules, with direct employer contributions reducing Medicare responsibilities.

State and local baseline spending is primarily Medicaid, although significant sums are currently spent on other programs, most notably direct payments to hospitals. Under reform, Medicaid savings will be redirected under maintenance of effort requirements for use in paying discounts for low-income populations in the alliances.

APPENDIX A
Small Firm Discounts

Average Firm Payroll	Size of Firm ⁶ (Number of Employees)		
	Less Than 25	25 to 50	50 to 75
Less \$12,000	3.5%	4.4%	5.3%
\$12,000-15,000	4.4%	5.3%	6.2%
\$15,000-18,000	5.3%	6.2%	7.1%
\$18,000-21,000	6.2%	7.1%	7.9%
\$21,000-24,000	7.1%	7.9%	7.9%
Greater Than \$24,000	7.9%	7.9%	7.9%

⁶Because 75 workers was not a firm size break included in the data sets being used, modelers were asked to use a firm size of 100 for this subsidy calculation. Given that the subsidies will apply only to firms up to size 75, the results overestimate the subsidy costs.

Mr. WAXMAN. One of the crucial elements in the financing of any health reform is the cost of the covered benefits. In her testimony this morning Dr. Rivlin stated that the administration tried to be as conservative and realistic as we could in estimating these costs, choosing the higher of two different agency estimates after months of analysis.

Later this afternoon we are going to hear from an independent actuary, Mr. Dale Yamamoto of Hewitt Associates, that the price of the President's benefits package by their estimates is between 19 percent and 59 percent higher than the price published in the President's report on October 27, depending on family premium category. Dr. Thorpe, can you tell us whether the administration used the October 27 preliminary estimates as the basis for today's testimony, and, if so, why these might be lower than the premiums estimated by the Hewitt Associates?

Mr. THORPE. Sure. The premium estimates that you see are the same we have had for several weeks, \$1,932 for a single policy, et cetera. As I mentioned in my oral remarks, one would expect to receive very different premium estimates from different groups making them.

Primarily, the major difference is the following: It depends on what your starting point is. For example, if I am an insurance company or an employer benefits firm and if I base a premium estimate on my existing rate book or book of business depending upon characteristics of who is in that group, large employers who have selected a consulting firm because they have high costs or if I did an estimate because I primarily insured small firms with high administrative costs, et cetera, one could imagine that you would get different estimates of the premium costs depending on the characteristics of who you actually have experience providing insurance for. So I would imagine when we see estimates for different groups, many will be higher, many will be lower.

We are trying to come up with a nationally representative estimate that includes all populations, small and large employers, the uninsured, people who buy individual policies, the Medicaid program, et cetera. That is why we feel that our starting point, the National Health Accounts is the most appropriate baseline to benchmark any premium estimates to, because it is nationally representative.

The other premiums are internally consistent, and I am sure that the methodology is fine, but is not a nationally representative estimate of the premiums.

Mr. WAXMAN. In a recently published article concerning financing of the President's plan Dr. Wilensky, who will testify on the next panel, writes, I had expected one of two scenarios: modest benefits but substantively and politically credible financing, or expansive benefits and correspondingly more difficult and politically unpalatable financing strategies. Expansive benefits and less than credible financing was an unexpected combination.

The question now is why that combination was chosen by a team with no shortage of health policy depth and whether it will prove to be a wise political strategy. Dr. Thorpe, as a member of the President's health policy team, do you have any reaction to this?

Mr. THORPE. Sure. I think we within the administration agree and those closest to developing the numbers believe that the financing is entirely credible. I think it sounds like from the statement that Dr. Wilensky was starting from the standpoint that there is no waste and inefficiency in the system and that substantial savings couldn't be taken out. We simply disagree.

You have seen in detail the projected Medicare-Medicaid programmatic savings as well as the savings that we know are sitting there in the private sector. We think in terms of how the numbers add up and the credibility we are comfortable with it. In terms of expansive benefits we provide a comprehensive benefit package which sits at the median of what is currently in the private insurance market largely because we wanted to make sure that we weren't taking benefits away from people and people were receiving a credible comprehensive set of benefits that we would all be proud of.

So we think in the administration that the financing is credible and over the coming weeks we will be happy to work with groups as they look at our methods and the way that we did the numbers.

Mr. WAXMAN. As you know, I have been extremely concerned about the caps that the President has placed on Federal subsidies for small employers, low-income people and the early retirees. These caps raise serious questions about whether health care will always be there and, if so, who other than the Federal Government will ultimately bear the responsibility for paying for it.

Dr. Rivlin told us earlier that in setting these caps you added 15 percent of the estimate of the subsidy costs, about \$44 billion, to cover potential behavioral changes that are difficult to model. Can you tell us what these potential behavioral changes are, why you chose 15 percent as a cushion and what do you think the chances are that the caps will be hit in any given year?

Mr. THORPE. I like to think of our estimates as having two sets of cushions. Our original basic estimates of the discounts we think for the reasons we have laid out are inherently conservative. In every case where there was a behavioral assumption we had it work against us so that it would increase our discount estimates.

The one example I gave you was an individual who works for a corporate alliance and another individual who works for a regional alliance. We put that family entirely in the regional alliance, therefore receiving discounts. In reality that is not likely going to happen, but it was a way of making sure that our discount estimates were higher than they otherwise would have been.

Over and above that, we have added on 15 percent. The process of coming up with the 15 percent was that we were trying to think of things in our proposal that could potentially happen that we didn't have a simple way of estimating. We tried to bound it in terms of what potentially would happen.

For example, there have been some estimates that we have done that looked at what might happen with early retirement—with our early retiree policy—and we looked at how that change in employment might occur. We then estimated what the change in discounts would be.

A second area, there could be—although through the legislation we tried to discourage this—opportunities for some lower wage in-

dividuals in high wage larger firms to splinter off. We think we have discouraged that in the legislation. It is still a technical possibility. We have looked at estimates of what would happen if that occurred, and we came up with an estimate of that.

Third is that we looked at what would happen with substantial economic fluctuations, in particular a substantial downturn in the economy. We looked at a 2 percentage point increase in the unemployment rate. That increased on a yearly basis our discounts by about \$4 billion.

We then added each of these up, and on top of that we put in an additional cushion of—I can't remember what it was—but those three factors did not exhaust the 15 percent. We put in more as additional contingencies. That was some of the process of how we arrived at this.

We tried to think behaviorally what would happen. We tried to be conservative with economic projections, and then we added some amount of money over and above that to be even more frugal.

Mr. WAXMAN. And, therefore, you think that the caps will never be hit?

Mr. THORPE. I think that the probability that they are hit is very, very low for both these reasons.

Our baseline estimates of the discounts I think are quite conservative because they represent behavioral changes that even in the baseline are not likely to happen. All dual-working couples will not get coverage through the regional alliances is an example of this. All firms under a hundred have our lower discount schedule, even though the legislation says firms 75 and below get it. So we have built in some conservative estimates in the first round.

In the second round, we added 15 percent, and we were trying to be as conservative with this as we could so that the likelihood of hitting these caps was as low as we could make it.

Mr. WAXMAN. On Friday we held a hearing on the impact of the President's plan on Medicaid beneficiaries and other low-income people. Diane Rowland of the Kaiser Medicaid Commission told us about 6 million poor people who are eligible for Medicaid now but were not receiving cash assistance under Aid to Families with Dependent Children or supplemental security income will not receive any assistance with the minimum cost sharing required under the President's plan.

These 6 million or so include the medically needy who are eligible for Medicaid because of their high medical expenses as well as the pregnant women and young children we made eligible for Medicaid over the past several years because their income is below a certain poverty threshold. In many cases, they have no more ability to pay the cost sharing requirements than do cash assistance recipients, who will get assistance under the President's plan. In all cases they will be worse off under the President's plan than under current law, which prohibits any cost sharing with respect to services for pregnant women and children and which allows only nominal cost sharing for other services to noncash eligibles.

When we asked the HCFA administrator, Mr. Vladeck, about this, he told us that the distinction between cash and noncash was related to the financing of the plan but was unable to tell us how much the cost of the plan was reduced by requiring the 6 million

noncash beneficiaries to pay more. Can you give us this figure? Or, put another way, how much would it cost to extend noncash eligibles the same protection against cost sharing that the plan extends to AFDC and SSI recipients?

Mr. THORPE. Two points on this question. The first and one of the biggest advantages that the medically needy have with receiving coverage through the alliance is that they don't have to spend down to receive medical care services any more, that they receive coverage from day one. Under that program you have to virtually exhaust your resources in order to become eligible for the Medicaid program. That will no longer be the case. Those individuals would get coverage from day one.

Second, with respect to the lower out-of-pocket payments, we would be happy to look at it. I have not looked at this specifically for the other low income population. As you pointed out, the cash assistance population would receive the lower cost sharing within the alliance.

Mr. WAXMAN. We tried to sever the link between welfare and Medicaid, and we did that with low income pregnant women and their children. A lot of those people are quite low income. They are going to have to come up with that cost sharing. They are not in the same situation as the medically needy. Do you have any explanation for them being required to come up with the cost sharing or the cost figures for them to be protected the same way as the cash recipients?

Mr. THORPE. I think the concept was to have everybody contribute something on an accounted basis for medical care. Whether the \$10 is the right figure is something that we would be happy to work with the committee on and look at.

Mr. WAXMAN. Mr. Moorhead.

Mr. MOORHEAD. Thank you, Mr. Chairman.

I would like to call your attention to the chart that is over there on your left. Mr. Thorpe, on this chart the last column has the administration's estimated costs for single and family coverage of the Clinton standard benefits package. These numbers are taken from page 112 of the book, Health Security: The President's Report to the American People. The premium for single coverage is \$1,932 and that for family coverage is \$4,360.

Let's look at comparisons which are consistent with the testimony that will be given by the actuaries from Hewitt Associates.

Column one has data from a 1992 HIAA employer's survey. This data was adjusted for the standard benefits package and for the new groups receiving coverage from the alliances, the uninsured, early retirees and Medicaid recipients. However, this analysis is based on 1992 dollars unadjusted for inflation. This study found the cost of single coverage to be \$1,980, and the cost of family coverage to be \$4,980. This is 14 percent above the administration estimate.

Column two presents results from a 1993 KPMG Peat-Marwick study. Again, this data is adjusted to reflect the administration's standard benefits package and is adjusted for coverage of the uninsured, early retirees and Medicaid recipients. However, this analysis is based on unadjusted 1993 dollars. This study estimated the

cost of single coverage at \$2,064 and family coverage at \$5,448. This is 25 percent above the administration's estimate.

Finally, column four presents the premiums from two plans offered in the Federal Employees Health Care Program. The package of benefits offered in these plans are not nearly as rich as the administration's standard package, particularly in the mental health and substance abuse areas. In addition, these premiums are not adjusted for the coverage of the uninsured and early retirees.

The Maryland IPA is an HMO. Its premiums are 26 percent above the administration's estimate. BACE is a mixed plan with fee-for-service and a pro option is available only to the congressional employees, which has a much younger demographic mix than the general population. Its premiums are 31 percent above the administration's estimates.

Mr. Thorpe, these estimates are just representative of many others. Can all of the actuaries in the United States be wrong? Every actuary who has priced your benefits plan has produced estimates which are significantly higher.

Let me ask you some questions. Has the office of HCFA actuaries supplied you with an actuarial memorandum verifying your cost of estimates? If so, would you make it available to this committee?

Mr. THORPE. I would be happy to.

Mr. MOORHEAD. Has it supplied you with one?

Mr. THORPE. I am not sure exactly what that is. Yes, these estimates were produced by our Office of the Actuary and completed by our Chief Actuary.

Mr. MOORHEAD. Have any of your microsimulation models of actual expenditure data been verified against actual premium and cost data to determine the validity and reliability of the models?

Mr. THORPE. Yes. In fact, very early on in our exercise we did a reconciliation exercise looking at the standard option Blue Cross/Blue Shield plan within the Federal health plan. We had the Office of the Actuary as well as AHCPH within HHS reconcile the experience within the Federal health plan to their premium estimates, and it was an interesting exercise because one could see quite visibly why one would come up with different estimates based on a nationally represented sets of premium estimates, which is what we are doing for all populations versus another set of estimates which are based on a sample of individuals who have specific demographics which include retirees, annuitants, and so on.

Mr. MOORHEAD. Could you make those available to us?

Mr. THORPE. Be happy to.

[The information follows:]



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration**Memorandum**

Date March 9, 1993

From Chief Actuary
Health Care Financing Administration

Subject Reconciliation of Microsimulation Results--INFORMATION

To Ken Thorpe
Deputy Assistant Secretary for Health Policy, ASPE

Introduction

The Office of the Actuary (OACT) has completed a series of comparisons related to our Special Policy Analysis Model (SPAM). These comparisons stemmed from the recent calibration exercise in which we were asked to simulate the Blue Cross / Blue Shield (BC/BS) Standard Option plan of the Federal Employees Health Benefit (FEHB) program. Subsequent to the exercise, we compared (1) the output of the SPAM model with premiums for the FEHB BC/BS Standard Option Plan; (2) net premiums for FEHB BC/BS Standard Option and Conventional Plans reported by the Health Insurance Association of America (HIAA); and (3) SPAM output with National Health Expenditure (NHE) projections and population projections.

Our conclusion is that the SPAM model produces an appropriate level of benefits. SPAM results are consistent with the actual experience of the FEHB BC/BS plan after adjustment for demographic composition of the populations; the small differences that remain are attributable to coverage differences and other factors such as geographic dispersion. Further, the results seem appropriate when compared to HIAA data, and are internally consistent with the national health accounts.

SPAM compared with FEHB

A face-value comparison of SPAM output with the FEHB BC/BS Standard Option premium suggests that SPAM output is significantly understated. The SPAM per-capita cost for the 169 million persons covered in the calibration exercise is \$968 in 1994. In contrast, the 1993 FEHB BC/BS Standard Option Plan premium is \$2096 for Self-only and \$4404 for families.

However, that comparison above is distorted by characteristics of the FEHB. First, a substantial number of the persons covered by the FEHB BC/BS Standard Option are annuitants, and a significant portion of those are elderly without Medicare coverage. In contrast, the calibration exercise specifically excluded the elderly and those in insurance families without a full-time employed adult. Second, the average age of the policy holders in the FEHB plan is greater than the average age of the family heads in the SPAM calibration run.

To determine the magnitude of these factors' effects, we first obtained FEHB BC/BS Standard option enrollment data from the Office of Personnel Management (OPM). These data show that 348,000 of the 633,000 Self-only enrollees are over age 65; 54,000 of them do not have Medicare. For Family coverage, 300,000 of the 824,000 contracts are held by persons over age 65 and 46,000 of those are without Medicare coverage.

Next, we developed per-contract costs from the SPAM to apply to the FEHB enrollment data. To proxy active Federal workers and their families, we used SPAM insurance families with employer-sponsored insurance (regardless of industry) where at least one adult worked and was not on Medicaid. To proxy Federal annuitants and their families, we used SPAM insurance families where at least one adult was retired with employer-sponsored insurance and not on Medicaid. To simulate benefits (either Self-only or Family) under active workers' policies, we combined private health insurance benefits and out-of-pocket expenses from the SPAM file. We used that same definition of expenses for annuitants with Medicare coverage, simulating FEHB secondary coverage. For annuitants without Medicare coverage, we added Medicare benefits from the SPAM file, simulating coverage by FEHB of those annuitants' total covered health care costs.

When weighted by FEHB enrollment, the SPAM output closely resembles the actual figures from OPM. The SPAM result was slightly high for Self-only policies and slightly low for Family policies (Attachment 1). SPAM produced an average annual cost of \$2296 per Self-only policy, compared to the BC/BS cost of \$2121. SPAM produced an average annual cost of \$410 for Family policies, compared to the BC/BS cost of \$4457. The weighted average of Self-only and Family BC/BS policies is within 4 percent of the same weighted average from SPAM. About

half of the difference is accounted for by FEHB BC/BS dental coverage. Dental coverage was specifically excluded from the calibration exercise. In addition, the differences in the figures reflect the (possibly) atypical geographic distribution of Federal employees and annuitants, differences in family size, and many other factors.

FEHB compared with HIAA

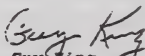
Having reconciled SPAM with FEHB BC/BS Standard Option, we next compared FEHB BC/BS Standard Option with HIAA Conventional Plan net premiums. This step provides a further "real world" check for reasonableness. Unfortunately, detailed information on populations covered, benefit packages, and cost-sharing provisions is not available, permitting only the grossest of comparisons. It appears that FEHB BC/BS Standard Option net premiums in 1991 were quite high compared to those of all Conventional Plans in the HIAA data base (Attachment 2). Within the limits of the data, this comparison suggests that the SPAM produced an appropriate premium for the policy evaluated. This suggestion, of course, is valid provided that the policy were being sold only to employed workers and their families under the age of 65 with no selection bias, as specified in the calibration exercise.

SPAM compared with NHE

The third comparison we made was an internal consistency check on the output of the SPAM. We expressed the aggregate SPAM results for private insurance and out-of-pocket health expenditures from the calibration exercise as proportions of total private and out-of-pocket health expenditures from the NHE projections. We then compared this proportion with the proportion of the total population covered in the calibration exercise. The SPAM aggregate dollar estimates constitute 57.8 percent of private insurance and out-of-pocket payments, and the population covered constitutes 64.0 percent of the total population. We felt these figures were consistent, considering that the population covered by the calibration exercise includes people most likely to have high levels of private insurance coverage. These are also the people most likely to be healthy compared to the elderly and the not-fully-employed young in the remaining population.

Conclusion

Based upon these comparisons, we feel comfortable with the ability of SPAM to produce accurate results. The comparisons suggest that the model output is reasonable. However, we are continuing to refine the model, but these refinements fall under the general heading of "fine tuning" rather than "major repair."


Guy King

- Attachment 1: Reconciliation with FEHB BC/BS Standard Option plan
- Attachment 2: Comparison of FEHB BC/BS Standard Option and HIAA Conventional Plan Net Premiums
- Attachment 3: Comparison of population and spending amounts based upon NHE projections

Blue Cross Standard Option Enrollments without Coordination of Benefits

1991 Enrollment

	0 - 24	25 - 34	35 - 44	45 - 54	55 - 64	65 - 74	75 - 84	85 +	Total
Self									
Active	8,829	63,269	60,484	47,566	28,936	6,088			215,172
Retired w/o Medicare				15,493	51,773	28,479	19,335	6,435	121,515
Retired w/ Medicare					2,364	148,471	117,048	28,447	296,330
									633,017
Family									
Active	2,607	68,943	152,448	132,060	63,290	8,233			427,581
Retired w/o Medicare				12,772	82,236	33,429	10,591	1,891	140,919
Retired w/ Medicare					1,180	164,582	81,815	8,406	255,983
									824,483
									1,457,500

1994 SPAM Per Policy

Self									
Active	686.02	802.44	796.60	1492.14	1547.86	3470.52			1124.22
Retired w/o Medicare				2502.72	2849.93	4822.21	6581.13	5361.10	3994.57
Retired w/ Medicare					3998.71	2389.77	2690.57	1641.99	2449.63
									2295.67
Family									
Active	1842.37	2509.49	2534.58	3454.76	4369.60	3844.10			3107.34
Retired w/o Medicare				5401.52	4647.56	8834.10	11473.69	14895.67	6359.58
Retired w/ Medicare					4117.07	4499.37	4706.68	3695.13	4537.45
									4107.23
Total									3320.44

1993 BC/BS
Premiums
adjustment for
loading 21212

4457

**Comparison of Conventional Insurance Plan Net Premiums
with FEHB BC/BS Standard Option Net Premiums 1991**

	<u>Family</u>	<u>Individual</u>
FEHB BC/BS ^{1/}	\$3402	\$1619
HIAA Conventional ^{2/}	\$3121	\$1325

^{1/} Loss ratio of .92 provided by OPM actuaries

^{2/} Loss ratio of .741 provided by A.M. Best

1994 PROJECTIONS

	PERSONAL	PRIVATE	PHI	OOP	OPVT	PHI+OOP
PERSONAL	890210	473988	257807	185725	30456	443532
-DENTAL	43634	41952	18985	22967	0	41952
-HHAs	14220	3314	919	1503	892	2422
-SNFs	83214	36119	850	33825	1444	34675
-DURELS	7508	5490	648	4843	0	5490
-NON-RX	28047	28047	0	28047	0	28047
TOTALS	713587	359066	236406	94541	28120	330946

SIMULATION FOR WORKING <65

	153223	38046	191269
% of tots	64.8%	40.2%	57.8%

Table 5
Population counts by reason for disqualification

	Families		People
	N	Weighted	
Total	75,878	128,878	265,224
Disqualified			
Age 65 or older	xxx	xxx	30,422
No full-year worker	32,198	52,814	60,930
No full-time worker	761	1,268	1,554
All adults on Medicaid	618	991	2,610
Qualified family	42,301	73,805	169,708

Source: Health Care Financing Administration, Office of the Actuary

MF03.@BLS3350.LIB.CNTL(SPAM9410)
MF03.@BLS3350.SPAM.CL94.INSFAM.SAS(CL94)
9:59 TUESDAY, FEBRUARY 23, 1993

Mr. MOORHEAD. I have noticed with the Blues, the standard option is quite low compared to the others. I don't quite understand why because the Blues have supplied the services for BACE, which is a government-wide health plan, and BACE is not able to make an agreement with them for this year that was reasonable for the members. They were much—the Blues were much higher than the plan they got.

Yet when they listed their standard option it is below what BACE will be. I don't know what they left out there because we are all considering what health plan to take ourselves. I know you picked the cheapest one of all when you pick what the standard option was for the year. If you look at their higher option it is several times as high as anything else, and there must be some strange reason for those figures.

Mr. THORPE. In general, Mr. Moorhead, the reasons why you are going to see and we will see as well in the upcoming months several dozen estimates of this benefit package—I would make basically four points.

One is that our role was to come up with a national estimate based on a national average for people covered through the comprehensive benefit plan. What exists in the rate books and experience of others who are making these—estimates—are the experience whether regionally based, special demographics, et cetera, but the demographics and the average experience of people within the Blue Cross plan, Aetna, large companies that select employee benefits, corporations or consultants because they have high costs—

Mr. MOORHEAD. We have the figures that you have quoted. Aetna is higher than that standard.

Mr. THORPE. One of the reasons is because their demographic mix is higher than the average demographic mix that we are insuring. That would be the first thing to look at is what the average demographics are.

Mr. MOORHEAD. But your cost for the Nation as a whole will be much higher than the coverage we get on the Hill because the ages here are much lower than what they will be for the average you have to cover.

Mr. THORPE. The Washington area is a higher cost medical market than the national experience is.

My second point is that you are looking at regional estimates. Even with our premium estimates you are going to see substantial variations in the cost of these benefits in New York versus Idaho.

Mr. MOORHEAD. With all these other estimates being so much higher than yours, if you have underestimated the cost of the benefit package by 25 percent, what does that do to the plan's financing and premium subsidies?

Mr. WAXMAN. The gentleman's time has expired, but we would like you to give an answer to that question.

Mr. THORPE. First of all, again, that is—our baseline for this estimate is the National Health Accounts so our comprehensive benefit package is pegged to the National Health Accounts. So we think almost definitionally—and when you see CBO come up with their estimates, their estimates would be pegged to their national health account baseline which is supposed to be nationally represented over the entire population.

Our best estimate is what you see in front of you. It includes a national definition of who is covered. It pulls out of the premium estimate uncompensated care as the statute dictates. It also brings in uninsured individuals at cost, which is another saving. It excludes annuitants from the premium cost which is typically found in rate books of most insurers. We think this is the best estimate based on the population we are supposed to be insuring and estimating for.

Mr. MOORHEAD. That wasn't the question. The question was, if it is supposed to be more in line with these estimates, your 25 percent off. What does that do to the plan's financing and subsidies?

Mr. THORPE. We haven't made a calculation of a 25 percent higher premium, so I couldn't answer that specifically for you now, Mr. Moorhead.

Mr. WAXMAN. Thank you, Mr. Moorhead.

Mr. Wyden.

Mr. WYDEN. Let me apologize for coming in late. I don't know if you were here earlier, but I have a special interest in this situation in the private sector, particularly proportional distribution. How much money—and let's start just on the private sector side—will the new participants in the health insurance risk pool be contributing?

We essentially have a significant number of new people in the private sector paying in. How many of them are there and how much more are they going to pay?

Mr. THORPE. We are working on those statistics. Let me see if I understand your question. It sounds like if I am correct you are interested in the change in spending by the business sector, the household sector and the government.

Mr. WYDEN. I want to know who is going to be paying directly for health coverage after the mandate that wasn't paying directly before the mandates. Who are they? How many of them are there? And how much they are paying in?

Mr. THORPE. Let me start with a couple of populations. First, is that if you look at individuals who receive employer-sponsored insurance throughout the year, this is about 40 million families, something on the order of 95 million individuals. If you look at what they pay today versus what they will pay under reform, what the analyses suggest is that in 1994, if the plan were implemented immediately, that approximately 70 percent of those individuals would pay the same or less for similar benefits and that on average throughout the year the average person who saves money would save about \$738 per year.

Mr. WYDEN. Seventy percent under your projections would save on the average \$738 per year?

Mr. THORPE. The 70 percent figure are people who would spend the same or less. Of those who spend less, they would save—their average savings, if you will, would be \$738 per year.

Mr. WYDEN. Of the 70 percent how many would spend less?

Mr. THORPE. I think—why don't we keep on, and I will have somebody tell me. I do have that with me.

Mr. WYDEN. That would be very attractive and powerful. If a significant number of people in this country have their health spend-

ing reduced by \$738 per year, people like myself who feel the President is headed in the right direction would sure like to know it.

Mr. THORPE. Of the entire 40 million families, 15 percent of them would save \$1,000 or more per year. You look at this after the plan is fully implemented in the year 2000, and you get both the coverage and cost containment pieces of this in operation, that something more than 70 percent would spend the same or less—we have estimated 72 percent and in 1994 dollars the average savings is \$1,075. By that year 23 percent of all families, that is of the 40 million families that we have been working with, that 23 percent of them would save \$1,000 or more by that year.

Mr. WYDEN. Of the 30 percent who are going to be paying more, according to your projections, how much more do you believe they will average in payment?

Mr. THORPE. That 30 percent falls into two groups. About half are getting more comprehensive and better benefits; the rest are receiving similar benefits. The average yearly expenditures among those spending more would be \$290. So for the savers, it is \$738 per year. For those individuals that spend more, probably for the more comprehensive benefits, they would spend about \$290 per year more.

Mr. WYDEN. What kind of people are going to be paying less?

Mr. THORPE. The kind of people that are going to be paying less are essentially many individuals who work in smaller firms that have policies with high administrative costs. There are a lot of low-income individuals from particular families that are going to be paying less because of lower administrative costs. Individuals that in today's market that because they have become sick or had a bad experience and are making an experience-rated premium that is quite high will save money. Those are the ones that immediately come to mind.

The ones that will be paying more are largely individuals that in today's market have been able to seek out insurance companies because they are healthy, get to negotiate low rates, which are transient in nature because the minute they become ill those rates go through the roof. So the savings in that sense are somewhat illusory because they are not stable. That gives you some sense of who these individuals are.

Mr. WYDEN. I would just pass on that the sooner that you all can sharpen these figures—because people really want to know how many billions of dollars in the aggregate are going to be contributed by employers and employees as a result of the mandate and who is going to win and who is going to lose. To the extent that you all can sharpen these numbers up this is, in my view, going to be one of the two or three things that really drive this debate.

What I have been concerned about and Dr. Rivlin was here, and somebody whom I have enormous respect for, all the discussion is always on the government side. You know, we had two or three pages full of government savings and projections and then there is a sentence saying 74 percent of the money comes from the private sector. That is the area where we don't have the specificity, so we look forward to working with you closely on this.

Mr. WAXMAN. Thank you, Mr. Wyden.

Dr. Thorpe, we appreciate you being with us and answering the questions. We may have other questions for you to respond to in writing for the record and would appreciate it if you would do so.

We have been summoned to the House Floor to vote. We will recess for as long as it takes to get there, and come right back.

[Brief recess.]

Mr. WAXMAN. Our final panel today consists of three witnesses from outside government. Gail Wilensky is a Senior Fellow at Project HOPE. She was the health and welfare policy advisor to President Bush and was Administrator of the Health Care Financing Administration from 1990 to 1992. Dale Yamamoto is the Chief Health Actuary for Hewitt Associates. He is accompanied by Frank McArdle, Manager of the Research Group. Kenneth Abramowitz is a Senior Research Analyst with Sanford C. Bernstein and Company.

Thank you all for being here today. Your prepared statements will be included in the record in full. We would like to ask each of you to limit your oral presentation to no more than 5 minutes so we have a full opportunity for questions and answers.

Dr. Wilensky.

STATEMENTS OF GAIL R. WILENSKY, SENIOR FELLOW AT PROJECT HOPE; DALE H. YAMAMOTO, CHIEF HEALTH CARE ACTUARY, HEWITT ASSOCIATES, ACCOMPANIED BY FRANK McARDLE, RESEARCH GROUP MANAGER; AND KENNETH S. ABRAMOWITZ, HEALTH CARE ANALYST, SANFORD C. BERNSTEIN & COMPANY

Mr. WAXMAN. Dr. Wilensky.

Ms. WILENSKY. Thank you, Mr. Chairman. It is a pleasure to be here in front of you again and to have the opportunity to testify.

I will summarize my comments by making some observations about the financing of the administration's proposal as it relates to Medicare, Medicaid, overall spending rates and accuracy with regard to previous attempts to forecast expenditures. I know you have gone through many hours of testimony with regard to the administration's proposal, and so I only want to touch on some of the highlights.

First let me comment on the basic funding from the public sector side, that is the \$124 billion that is due to come from Medicare and the \$65 billion that is due to come from Medicaid financing. There is an additional \$40 billion that will come from other government sources.

I regard the amounts that are being taken from Medicare as of sufficient concern to want to raise these for your consideration. The administration has said that mostly it is taking away from moneys that used to go for uncompensated care which would no longer be an issue if everybody had insurance.

But as I look at the \$124 billion that does not seem to be the case at all. Well over half seems to be directed to provider payments, another portion to utilization. This is on top of the \$56 billion reduction in baseline spending that was included in the economic plan.

If there was an interest and desire to change the nature of the Medicare program, to change the benefits, to change the population

served or to change the fundamental incentives, it might be possible to talk about amounts as large as \$124 billion, amounts as large as \$180 billion; but under the present circumstances where the benefits and in the program and the population are the same, in fact the benefits expanded, that seems to be an unreasonable and unwise thing to do and a very impolitic thing to do, but I will leave that to your decisions.

It is not, however, something that will simply come because uncompensated care will no longer be relevant.

With regard to Medicaid, I am personally less troubled in large part because of the substantial amount of money that is provided from the disproportionate share payments, an issue that I have had many discussions with you on in the past.

But there are some areas where I have some concern. The first has to do with the assumption that a 95 percent cap would be adequate to start the funding in the alliance for Medicaid individuals. I would presume that that is also something that would cause you distress and, in addition, having the Medicaid increases be subject to the CIP cap will put an enormous amount of strain on the populations that have been served, traditionally populations that have had a variety of special needs.

Spending rates being presumed as appropriate for the United States. This is an issue that you have heard before, so I only want to mention it quickly in passing. What is being presumed is that the United States can go from a situation where it has had very high rates of spending increase, rates that have caused us all concern, to a point where it will have lower rates of spending increase than any western industrialized country, substantially less than Germany, than the United Kingdom and Canada.

We all want to see spending rates reduced. I think it is possible by changing incentives to do so. But I think the notion of going to CPI, which is the most stringent measure of inflation there is, in 3 years in the private sector, is unreasonable and unwise, and I don't think it will happen no matter what the legislation says.

The fourth point has to do with our ability to correctly predict program changes. This is an area where you have had more than experience than I have, but in my few years of Government it is clear to me that even with the best of intentions and the best of predictions by HCFA, by OMB, by CBO, our ability to predict has been dismal at best.

Our errors are almost uniformly of a single direction. That is, we tend to underestimate spending and overestimate savings, and when you are talking about amounts that are as great as what is being envisioned in health care reform that is something to make you stop and pause.

It is particularly difficult because of the entitlement caps that will be in place. They will put enormous stress on the alliances, the purchasing groups and on the beneficiaries that will be covered. The promise of new benefits seems to me greater than anything that we can deliver in the amount of time and the amount of

money that has been proposed, and that while we all want to see health care reform, promising more than we are prepared to deliver and getting there faster than seems likely appears to be a very unwise move.

Thank you.

Mr. WAXMAN. Thank you, Dr. Wilensky.

[The following article was submitted:]

Clinton's Tooth-Fairy Financing

By Gail R. Wilensky

The health care reform debate began in earnest with President Clinton's address to a joint session of Congress on September 22, 1993. In his speech, widely regarded as an impassioned, well-crafted call to action, the President announced six principles underlying health care reform: savings, security, simplicity, choice, quality, and responsibility. In the initial public announcement and in subsequent comments, the President has repeatedly said that everything except the fundamental concepts of universal access and shared responsibility is "on the table" for negotiation, thus signaling his willingness and desire to negotiate a bipartisan solution.

The President's formal call for health reform has been met by what can only be described as an initial round of euphoria, with pledges of bipartisanship and generalized support from the Republican and Democratic leadership in Congress and the leaders of most interest groups. While there can be some debate about how deep that support actually is, there is little doubt that the mood in Washington and in the country is to make a serious attempt to

Even President Clinton's supporters say his proposal to finance health reform is politically unrealistic. It's that — and more. His plan to raise \$441 billion over five years would reduce services to elderly and poor Americans, assumes savings unmatched anywhere in the Western world, and ignores the federal government's dismal track record in forecasting what new benefits will cost.

resolve some of the difficult issues of health care reform.

Critical Differences

Despite this genuine sense of good will, however, there are critical issues separating the Administration and the congressional Democratic leadership from the Republican leadership and conservative Democrats, more than might be discerned from the current rhetoric. Most notably these include the Administration's proposal for an employer mandate, with its 80/20 financing split; a spending limit enforced by insurance premium caps; and a highly regulatory version of a

National Health Board and Health Alliance structure. These policies are not as readily negotiable as they appear on the surface, yet each will have to be dealt with before legislation can be completed.

Despite the critical issues that separate leadership Democrats from Republicans and conservative Democrats, there is one issue on which there is little disagreement: the President's financing strategy. Analysts may differ about the rationale underlying the President's plan, the potential impact on the deficit, or the expected levels of spending or savings, but a high level of skepticism regarding the reliability and the feasibility of the financing estimates seems to be nearly universal.

A thorough critique of the financing proposal is beyond the scope of this article. What I have attempted to do here is review what's being proposed; explore the



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politics and substance of Medicare and Medicaid cuts; make international comparisons with proposed spending caps; outline the potential for underestimating spending and overestimating savings; and review the pros and cons of the Clinton strategy, which I prefer to call "funding by the tooth fairy."

The Clinton Proposal

According to Administration estimates, the Clinton health care plan will cost \$700 billion to implement over a five-year period. The Administration proposes to pay for these expenditures by shifting \$259 billion in Medicare and Medicaid expenditures to the private sector via the employer mandate strategy and to raise \$441 billion dollars over the five-year period.

Of the \$441 billion the Administration would raise to pay for the plan, \$285 billion comes from savings on federal health care programs and \$156 billion from increased revenue sources. The specific federal savings proposals are shown in Figure 1.

The mechanism used to generate the savings in Medicare and Medicaid is a government-imposed cap on the growth in health care spending under these two programs. Unlike previous discussions of spending caps, which sought to limit the rate of growth in certain areas of public programs, the Clinton Administration is proposing to place a cap on the growth rates of Medicare and Medicaid spending as well as on the growth rate of private health insurance premiums. The caps for both the public programs and the private health insurance premiums phase in over a three- and five-year period, respectively. When fully phased in, the growth rates in spending will be limited to the Consumer Price Index (CPI) plus the annual popula-

tion growth. Applying these caps is expected to slow the growth rate in Medicare from 11.6 percent in fiscal year 1994 to 4.1 percent in fiscal year 2000, producing \$124 billion in savings that can be "scored" or counted by the Congressional Budget Office (CBO) over five years. Similarly, spending caps will slow the growth rate in Medicaid spending from 16.5 percent to 4.1 percent in fiscal year 2000, generating \$114 billion in total Medicaid savings over five years. The impact of the caps on growth rates and the spending and savings generated under both Medicare and Medicaid are shown in Figure 2 (see p.16).

Similarly, the application of the cap slows the rate of growth of private health care insurance premiums from 7.4 percent to 3.5 percent by fiscal 2000.

Politics and Substance

The success of the Clinton health care reform plan, as it is currently outlined, depends on implementing unprecedented cuts in Medicare and Medicaid financing; savings of \$285 billion, or two-thirds of the plan's financing, comes from cuts in public pro-

grams, mostly Medicare and Medicaid.

But the political likelihood of savings even approaching this level is very low. Furthermore, it can be argued that cuts of this magnitude would be highly undesirable on substantive grounds, at least as currently configured.

First the politics. It barely has been three months since the President's budget plan was passed into law. Negotiating the \$56 billion dollars worth of cuts in Medicare and Medicaid for that proposal was extremely painful, for Democrats even more than for Republicans. Earlier proposals by the Senate for reductions exceeding \$70 billion were derailed by the liberals in the House and Senate, and the likelihood of getting this Congress to consider seriously additional cuts of \$124 billion is extremely low. Even in a town where arm-twisting has been elevated to an art form, there are limits to what political persuasion or threats can accomplish.

Furthermore, the desirability of Medicare cuts of the level being proposed is highly questionable, unless accompanied by other changes. It's important to note that the Clinton Administration has not proposed limiting the benefits under Medicare. In fact, it is proposing an expansion of benefits to the elderly, in large part financed by the proposed cuts. The Administration also is *not* proposing to reduce the size of the population now served by the Medicare program by changing eligibility criteria. Finally, it is not proposing to fundamentally change the incentives facing either Medicare beneficiaries or the physicians and hospitals providing services to them.

Thus, what is being proposed is a Medicare program that provides the same acute care benefits to the elderly, who have little reason to be concerned about costs since 80

Figure 1

Federal Savings

Medicare	\$124 billion
Medicaid	\$114 billion
Other Federal	\$47 billion
Total:	\$285 billion
	(FY 1996-2000)

Additional Tax Revenue

Tobacco Taxes	\$105 billion
Personal Income Tax	\$51 billion
Total:	\$156 billion
	(FY 1996-2000)

percent have Medicare plus some form of supplementary insurance, and who are being provided services by physicians who predominantly practice fee-for-service medicine.

The only way these cuts can produce the savings outlined in the Clinton plan is for the Administration to take a "slash and burn" policy in its payments to providers. The unspoken but clear conclusion of this approach is that the service level provided to the Medicare population of the future will bear little resemblance to what's being offered to today's elderly Americans.

Sharply reduced service levels necessitated by massive Medicare cuts would force at least some hospitals serving the Medicare population to close. Many of those remaining would have reduced availability of services and fewer funds for medical supplies, testing, and equipment compared to current service levels. Rural hospitals, with their low occupancy and relatively high Medicare populations and the so-called "Medicare-dependent" hospitals, with their high concentrations of the elderly, would have an extremely difficult time surviving.

There are, of course, a variety of legitimate ways in which Medicare spending can be reduced if policymakers are willing to change the

benefits, the size or income level of the population covered, or the fundamental incentives faced by consumers and providers of services. Even so, the \$124 billion in proposed Medicare savings, on top of the \$56 billion just legislated, would be extremely hard to achieve by the year 2000 because of the potential for service disruption as well as the severe economic dislocations which could accompany such reductions.

Medicaid Concerns

The politics and the substantive implications of the Clinton plan's proposed Medicaid cuts are more complicated. First, the reductions in Medicaid in the budget bill were minor compared to those in Medicare. And second, the explosive increase in disproportionate share payments in Medicaid — from \$1 billion in 1989 to \$16 billion in 1993 — makes available a substantial pool of funds not directly related to the provision of Medicaid services. It is likely, however, that \$20 billion to \$30 billion of the \$114 billion total will be difficult to achieve.

The proposal assumes that Medicaid spending on a per capita basis will start at 95 percent of the

current level and will be trended forward as sufficient payment for the proposed new benefit under the Clinton plan. But states' ability to accomplish this reduction will vary substantially, depending on their current level of Medicaid financing and the availability of pre-paid health care plans for their Medicaid populations, which have been shown to be the most likely way of achieving a 5 percent per capita savings in the program.

My conclusion regarding the likelihood and advisability of reductions in Medicare and Medicaid spending — the Clinton plan's single largest source of funding — is that it will not occur and should not occur unless accompanied by other program changes, particularly in the Medicare program. One can only assume that the absence of protests by the various groups representing the elderly imply that they also are highly skeptical of these reductions actually taking place. In fact, it may well be that they have decided to push forward for the additional prescription drug and home care benefits and let someone else worry about how these benefits will be financed, a dangerous precedent that the Clinton plan has endorsed. "Buy

Figure 2

Medicare Growth Rates							
	FY94	FY95	FY96	FY97	FY98	FY99	FY2000
Baseline	11.6%	11.2%	11.1%	9.5%	9.1%	9.0%	9.0%
Clinton Proposal	11.6%	11.2%	7.4%	5.7%	4.6%	4.6%	4.1%
Actual Cuts (in billions)	-	-	\$7	\$15	\$23	\$33	\$46

Medicaid Growth Rates							
	FY94	FY95	FY96	FY97	FY98	FY99	FY2000
Baseline	16.5%	14.3%	11.7%	11.6%	11.2%	11.0%	11.0%
Clinton Proposal	16.5%	14.3%	7.5%	5.7%	5.1%	4.6%	4.1%
Actual Cuts (in billions)	-	-	\$7	\$15	\$22	\$30	\$40

now, pay later," seems to be the theme of much of the Clinton plan.

International Comparisons

An important component of the President's proposal is the use of spending caps on private insurance premiums as well as on Medicare and Medicaid. Although these caps do not produce savings to the federal government, they allow the Administration to make several important claims. Private sector spending caps allow the White House to avoid charges of cost shifting onto the private sector, to promise cost containment of a predictable nature for the private sector, and to serve as the crucial link in the rationale that allows them to claim \$51 billion in added personal income tax collections.

The logic that underpins the last claim is that because health care costs will be limited in the private sector by the insurance cap, employers will increase wages faster than they otherwise would have, resulting in an increase in taxable earnings. Whether employers would actually increase taxable incomes or increase other forms of tax-sheltered incomes, such as other fringe benefits, and how much income tax receipts might decline from people pushed out of the health care sector also is unclear. But the likelihood of the CBO recognizing such a linkage before it approves additional government spending is remote indeed.

The Administration has repeatedly defended its use of spending caps in the public and private sector as reasonable and doable because of all the waste and inefficiency in the present health system. Aside from the fact that there is no empirical evidence to indicate that when these caps are put in place, only waste and inefficiency will be cut, there has not yet been adequate recognition of how

stringent the Administration's proposals are compared to the cost containment experiences of other Western countries.

According to Organization of Economic Cooperation and Development (OECD) figures for the years 1985-1991, German health expenditures grew annually at 2.9 percent above inflation, the Canadian single payer system grew annually at 4.8 percent above inflation, and the British nationalized system grew annually at almost 4.1 percent above inflation. With annual population growth projected at less than one percent in the U.S., the Clinton proposal predicts that health expenditures will grow at less than one percent per year after the year 2000, adjusting for inflation. This is a rate none of these countries has been able to achieve — even with global budgets, administered pricing, and a tight control on technology.

The Murky Crystal Ball

The President's proposed health care plan contains major benefit expansions that are financed, for the most part, by savings from the public sector. Whether those savings could or should be achieved in the manner that has been suggested is a question in and of itself. But an unhappy reality is that our historical experience with correctly projecting future expenditures or future savings is dismal, with the federal government consistently losing out. We systematically underestimate future expenditures, particularly those associated with new programs, and we systematically overestimate savings, particularly when they are associated with "cuts" from ongoing programs.

Examples of past mistakes abound. The Medicare program itself represents a prime example. In the 1960s, it was estimated that Medicare would cost about \$12 billion in

1990. In actuality, the cost was \$107 billion. The Health Insurance Trust Fund component of Medicare, also known as Part A, was off by a factor of eight. Part of the error was due to an expansion of benefits, but that probably accounted for no more than 10 percent of the error.

More recently, the 1990 budget agreement claimed "cuts" in Medicare and Medicaid spending of \$40

*In just five years,
Clinton predicts the
U.S. will go from
spending the
highest amount on
health to the
lowest.*

billion over five years. The ink was hardly dry on the agreement before new cost projections indicated a net increase, after the cuts, of \$60 billion for the same period.

And the ill-fated Medicare catastrophic legislation provides yet one more example of our inability to estimate the effects of changing a large public program. As part of the legislation, the three-day hospital stay previously required prior to a Medicare payment for a skilled nursing facility was abolished. Both the Administration and the CBO estimated that making this change would cost about \$150 million dollars for 1989, based in part on the results of a demonstration project completed just a few years before. In fact, the current best estimate of the cost of that change was \$1.4 billion. Being off by a factor of nine during the course of a single year is something that we should keep in mind as we propose new benefits for the elderly as part of health care reform.

It is not obvious why we consistently underestimate the cost of

government programs and overestimate the savings of reducing ongoing programs. Sometimes it occurs because we are introducing benefits or changes in areas where we have little experience and thus have great difficulty predicting what change will be. More often, it is because we fail to account for changes in behavior induced by the program that we have put in place. Physicians, hospitals, and medical suppliers respond to incentives implicit or explicit in the programs; beneficiaries of the programs do the same.

The potential for underestimating pressures for new spending in the President's program is staggering. Two stand out as obvious candidates. First is the new home care benefit for the elderly. In an aging population, the potential for seeking home care and being able to receive some medical benefits from home care is enormous. While the Administration has attempted to limit the eligible population by including certain restrictions on daily activities as a requirement for eligibility and specifying that only those who are at risk for institutionalization are eligible, our ability to predict who is truly at risk for institutionalization is notoriously poor. Once you provide an incentive for being classified as having one or more limitations on daily activity, the number of people so identified can be expected to increase exponentially.

A second area with a huge potential for cost overruns is the early retiree benefit. Offering to have the government pay 80 percent of the health care costs for individuals between 55 and 64 who retire may sound like a dream come true for manufacturers and other businesses that employ an aging labor force, but the potential for increasing the number of retirees in this age bracket is mind-boggling. With only three million of the 21 mil-

lion current 55- to 64-year-old population retired, the potential for underestimating the magnitude of this change — and its cost to the federal government — is obvious. The problem will only be compounded as the baby boomer population reaches the 55-year minimum age. Aside from the potential to increase spending, a policy that encourages early retirement is singularly inappropriate for an aging society with a low birthrate. The policy should be redesigned to encourage workers to stay in the labor force rather than giving them and their employers an easy out.

Surprising Strategy

Although the debate on the President's health care proposal is just beginning, there has been almost universal skepticism about its proposed financing strategies. The politics of the Medicare cuts are formidable, and the policy wisdom of promising current benefits at spending levels 20 percent below the currently projected levels is dubious. The potential for spending levels to be substantially greater than what has been estimated is present throughout the proposal, but is especially strong for the expansion of benefits to the elderly (home care and prescription drug) and the early retiree benefit. Add to this our consistent history of underestimat-

ing spending on new government programs and overestimating the effects of spending cuts, and it is hardly surprising that the plan has provoked charges of phony funding by friends and foes alike.

I was surprised at the strategy chosen by the Administration. I had expected one of two scenarios: modest benefits, but substantively and politically credible financing; or expansive benefits and correspondingly more difficult and politically unpalatable financing strategies. Expansive benefits and less-than-credible financing was an unexpected combination. The question now is why that combination was chosen by a team with no shortage of health policy depth and whether it will prove to be a wise political strategy.

Some have surmised that the President chose this combination as being good politics. He has already indicated a willingness to compromise on all but the most basic principles; thus this proposal represents only the opening kickoff. And, knowing that health care reform would be a difficult sell because almost 85 percent of Americans already have health insurance, most are satisfied with the quality of the care they receive, and that he was elected to office by fewer than half (43 percent) of voters, Clinton may believe that this approach is the way to buy support from various interested parties. What he's done is promise prescription drug and home health care to the elderly, additional support to a threatened Veteran's Administration health system, relief of early retirees' expenses, health insurance equal to that of the best of the Fortune 500 firms to all workers — and he's glossed over how we are going to fund all of this.

It's an interesting gambit, but one that appears to have provoked almost universal skepticism. It also seems to me to have been a short-

*The proposed
home care
and early
retiree
benefits have
enormous
potential for
cost
overruns.*

sighted policy and one that is fundamentally not helpful to the American public. As soon as legislation is presented to the Congress, CBO will produce an independent estimate of spending and financing. If the numbers are anything like what most analysts expect, the political benefits of this laundry list of promises is likely to be short-lived. Congress, but also the President, will be pushed to come up with real financing strategies or substantially reduce or delay benefits because of the budget rules.

The troubling aspect of the current strategy is that it feeds on the "something for nothing" mentality so prevalent among the American

public. For years we have said that we want everyone to have the health care that millionaires receive; easy access to every kind of health care, including expensive new technology; and no new spending or just a little bit more, paid for mainly by the other guy. What we need to do is to push ourselves to confront hard decisions. We need to ask ourselves what exactly we are willing to pay more for and do differently and what we are willing to do for the 15 percent of Americans who are doing without formal or regularized access to care. This is the fundamental issue that we must face as a country.

I'm not suggesting that we can't or shouldn't moderate spending. We can and should, but this alone isn't going to be adequate to fund the poor uninsured or help working uninsured gain benefits. Spending slowdowns certainly won't be enough to fund major new benefits unless we are willing to do with a lot less or accept health care that is a lot different than we have become accustomed to. We had better understand the answers to these questions before we pass legislation. Clinton's lofty speech to the American public notwithstanding, we have yet to start on this process. ✧

Mr. WAXMAN. Dr. Yamamoto.

STATEMENT OF DALE H. YAMAMOTO

Mr. YAMAMOTO. Thank you. Just by way of background Hewitt Associates is an employee benefits and actuarial consulting firm. We have been in business for more than 50 years now and serve more than 75 percent of the Fortune 500 companies in this country.

And I would like to stress that we do not represent anyone here today except for ourself. We do not lobby, but we do have a very keen interest in the public policy that is regarding the standard benefit package under health care reform.

I would like to express our gratitude for your invitation to have us here today and welcome our chance to share our professional expertise with the committee.

We feel what we bring of value today is to provide you with a set of cost estimates and also the extensive experience of our pricing and design consultants in the area of health benefit programs, and our pricing models that we have put together are based on actual claims data that represent over 8 million life years of experience.

This is the same model we used when we estimate planned cost for employers. So it is something that has been tested in the real world.

In the past, we have generally found that our cost estimates using this same model are within 5 percent of actual costs. So we feel confident that our database and the models that we have developed represent the expected health care costs for the currently insured population.

Something that we do not maintain is a database on the Medicaid and uninsured populations. So, as a result, we have made some estimates to try to reflect what the impact of including this group in the newly insured population would be. And we have made some estimates regarding the potential reduction because of the elimination of cost shifting that exists for current programs today.

Something else we have done, in addition to all these adjustments, is to adjust these costs to represent a national average cost based on the census data from the 1992 current population survey to reflect the different age and sex demographics from our database.

We have priced the standard benefit package that was included in President Clinton's health care reform package released on October 27th, on both the national average basis and for seven different geographic areas. Again, we are using the proposed statutory language, knowing it has been revised, which could change some of our estimates.

We have estimated the cost for the State, the benefit package in the first year of reform and realize there are some other costs that may be over and above these costs. For example, our costs do not reflect the potential guarantee fund assessments, any types of supplemental coverage or additional benefits that may be mandated by States.

In our written testimony, we provide you with a lot of different detailed cost estimates. I would like to point to a table that is on page 9 of our written testimony that compares our cost estimates

versus the preliminary pricing that the administration has given and the President's report to the American people booklet also released on October 27th.

As you can see on this table, like other estimates you have seen, ours are higher than the administration's. For example, for family coverage, our estimates for the high cost sharing plan are 34 percent higher than the preliminary cost, and there are also different variations by family categories. For example, the estimate cost for single adult is \$2,400 compared to about \$1,900 or 26 percent more.

We also felt it might be helpful for the committee to understand that there are significant variations in cost due to different geographic areas, as Dr. Thorpe had mentioned. On page 12 of our testimony, we show the cost estimates for seven different areas. The cost for the single adult range from a low of \$1,800 in Charlotte, N.C., to a high of almost \$4,200 in Los Angeles, Calif.

Mr. Chairman, these represent our best estimates of the cost of the standard benefit package that is specified under the Health Security Act, and based on information that we currently have available.

We appreciate Mr. Thorpe's description of the rigorous and elaborate methods they have used to develop their costs. But without further public discussion and review of specific assumptions that go into the calculations, we find it difficult to determine why our cost projections are different, although we have some clues to suggest.

We have given you a summary of our methods and assumptions that we have used. Hewitt Associates would welcome the opportunity to review and reconcile our estimates and those used by the administration. We feel it would be in the best public interest to have all the methods used by the administration and others put on the table for discussion and assessment.

Finally, we suggest no single number on the pricing will turn out to be exact. Rather, we anticipate Congress will consider a range of optimistic and pessimistic projections to appreciate the true financial implications of the package.

Thank you.

[Testimony resumes on p. 118.]

[The prepared statement of Mr. Yamamoto follows:]

Testimony

of

Hewitt Associates

Mr. Chairman and Members of the Committee, my name is Dale Yamamoto. I am with Hewitt Associates, and I am the chief health care actuary working out of our national headquarters in Lincolnshire, Illinois.

With me today is Mr. Frank McArdle of Hewitt Associates. Frank manages our firm's Research Group based here in Washington, D.C.

Hewitt Associates is an international consulting firm specializing in the design, financing, communication, and administration of employee benefit programs. We provide consulting services to over 75 percent of the Fortune 500 companies and have an active client base of over 2,000 primarily large employers. We have been in business for more than 50 years, and employ more than 3,500 associates in most of the states represented by this Committee.

We are honored to be here today. The subject of this hearing is one of the most difficult and important ones you will have to address as part of national health care reform. To his credit, President Clinton urged us all to engage in a constructive debate of his proposal and to be honest about those areas where we, collectively, don't have all the answers.

We at Hewitt Associates do not represent anyone here today except ourselves. We are not lobbyists or lobbying. But we do have an interest in sound public policies regarding the standard benefit package under health care reform, and we welcome the opportunity to share our professional expertise with this distinguished Committee as a public service.

What we will do today is draw upon our experience in designing health care programs for large employer populations to give you some preliminary reactions to the design of the President's proposed standard health benefit package; sketch out for you how it compares to a package for a typical large employer; and illustrate for you how the costs of the benefit are dramatically affected by the particular design of the program.

Our remarks about cost in relation to the President's proposal are necessarily preliminary because we do not have all the information we would like to have in order to truly cost out that design on a national basis; and because, as we understand it, the proposal itself is undergoing refinement in technical areas that could significantly affect cost. So we do not have the "answer" about precisely how much this program will cost, but we can estimate for you how much it might cost for a large employer population.

Where we particularly add value is through our large private database and extensive experience in designing health benefit programs. Our actuarial model is based on data from our claims database of private employers' experience for active employees. Our current claims database represents data from employers that accumulate to 8 million life years of experience. This data is supplemented by the actual, hands-on experience of our consultants and actuaries, who have helped large employers manage health costs. With this model, we can determine the cost impact of changing both the plan design and the delivery of health benefits. We have made adjustments to these costs to estimate the impact of the newly covered persons. These adjustments are discussed in Appendix A of our written testimony.

Hewitt Associates does not keep a database on the Medicaid and uninsured population's medical costs, and there is uncertainty and disagreement about what additional medical benefits this population might be expected to use when they receive coverage. If one assumes that the Medicaid and uninsured population would cost, on average, 20 percent more than the currently insured population, and if 30 percent of the population is Medicaid-eligible or uninsured today, then the additional cost for everybody would be 6 percent higher, which we have reflected in our prices of the standard benefit package.

The above assumption of a 20 percent higher utilization amongst the uninsured population may be a financially conservative estimate of expected costs. The uninsured population today is generally younger and, with the exception of the disabled population without public coverage, probably tends to be healthier than average. The 20 percent higher utilization may be more of a temporary "spike" in costs for a couple of years until the pent-up demand subsides.

Basic Health Security Act Plan Design Features

President Clinton's health care reform package includes a standard set of benefit plan provisions that must be offered to covered individuals. The following services are offered in the first year with other benefits added in the year 2001:

- Inpatient and outpatient hospital services
- Doctor visits
- Outpatient laboratory tests
- Emergency services and ambulance

- Preventive services, including physical exams, well-baby care, prenatal care, immunizations, mammograms, and Pap smears
- Prescription drugs
- Routine eye exams
- Eyeglasses (for children only)
- Dental services (for children and emergency services only for adults)
- Home health care (60 days)
- Extended care facilities (100 days per year)
- Outpatient physical, occupational, and speech therapy (60 days)
- Hospice care
- Durable medical equipment
- Mental health and substance abuse
 - Inpatient services (30 days per episode/60 days per year)
 - Hospital alternatives (120 days)
 - Psychotherapy (30 visits, with possibility of additional discretionary visits to avoid hospitalization)
 - Other outpatient services

Not Covered

- Services that are not medically necessary or appropriate
- Private duty nursing
- Cosmetic orthodontia and other cosmetic surgery
- Hearing aids
- Adult eyeglasses and contact lenses
- In vitro fertilization services
- Private room accommodations
- Custodial care

- Personal comfort services and supplies
- Investigational treatments (except for medically necessary or appropriate care provided as part of an approved research trial)

The Health Security Act includes a "high cost-sharing" option, a "low cost-sharing" option and a "combination" option. The high cost-sharing option is for plans that offer a traditional fee-for-service health care plan. This option's provisions include an initial deductible and coinsurance up to an out-of-pocket limit.

The low cost-sharing option is similar to an HMO, with the exception that every plan would have to allow individuals an out-of-network option with additional employee coinsurance payments of at least 20 percent. Copays are included for office visits.

Cost-Sharing Schedules

	Low (HMO)	Combination In	Out	High (FFS)
Preventive	100%	100%	100%	100%
Office Copay	\$10 copay	\$10 copay	20%	20%
Deductible	—	—	\$200/\$400	\$200/\$400
Coinsurance	100%	100%	80%	80%
OOP Max	\$1,500/\$3,000	\$1,500/\$3,000	\$1,500/\$3,000	\$1,500/\$3,000
Drugs	\$5 copay	\$5 copay	80% after \$250 deductible	80% after \$250 deductible
Mental Health	\$10 copay \$25 psychotherapy	\$10 copay	80%	80% 50% psychotherapy

The "combination" cost-sharing option is a blend of the high and low cost-sharing options with in- and out-of-network provisions. Conceptually, this is similar to point-of-service (POS) plans, although news accounts have described it as being a preferred provider organization (PPO). In this document, we have priced the combination as a POS plan, meaning that it includes a "gatekeeper" function that helps to control utilization and lower costs.

Relative Value of Plan Compared to Large Employer Plans

Before we discuss the costs of the proposed plans, we have reviewed the actuarial value of the high cost-sharing plan compared to other plans offered by large employers. Our database of plans that we have valued includes large companies from a variety of industries (Appendix B). Out of the 487 large companies that we included in our comparison, the Health Security Act high cost-sharing plan was ranked 431, with 1 being the "richest" plan. This means that there are 56 companies (or 12 percent) with plans that provide lesser benefits, on a relative value basis, and 430 large companies (or 88 percent) with more benefits. The main reason for the lower value of the initial proposed Health Security Act plan is the low adult dental benefits. If we only focus on the medical plan benefits, excluding dental, the proposed plan ranks number 227 out of 487. That is, there are 226 companies (or 46 percent) with richer medical benefits than the Health Security Act plan. Please note that these values are for total plan benefits; individual employers and employees pay varying shares of that total cost. In our experience, the degree of employer/employee cost sharing varies more than the plan designs themselves.

Generally, there are also variations between benefit programs for salaried and hourly employees. In some cases, hourly employees have greater benefits, especially when represented by a strong union; and in other cases, hourly employees have lesser benefits.

For example, in our database of plans for hourly employees, we show 50 percent of the collectively bargained plans are provided to employees at no charge. This is in contrast to 20 percent of salaried plans that have no employee contribution.

Cost of the Standard Benefit Package

The standard benefit package included in President Clinton's health care reform package as described in the October 27, 1993 legislative language was priced for seven geographic areas and a national average. Again, we are using the statutory language, knowing full well that it is in the process of being revised, which could change our cost estimates significantly.

The cost estimates provided are for the standard benefit package in the beginning of reform. There are other costs of health care coverage that the employer and the employee might be expected to incur, over and above these costs. For example, additional benefits may be mandated by states, as permitted under the Act, and supplemental insurance to fill in gaps between the standard package and current benefits may be provided to employees. The cost of the standard benefit package itself would be about 5 percent higher in 2001 than the initial package, because of scheduled changes under the Health Security Act for added mental health benefits and adult dental.

All three cost-sharing options were priced based on the current health care cost structures available. For example, we have assumed the fee-for-service plans reimburse providers under today's reasonable and customary schedule. We typically see current health plans covering health care costs up to the 75th or 80th percentile of "reasonable and customary" charges. In other words, 25 or 20 percent patients will have their doctors charge more than the plan considers a covered expense and eligible for benefit payment. To the extent that regional alliances can start out by negotiating fee schedules for providers below current levels, the costs would be lower.

The following table summarizes the results for the national average costs (per covered life) for the 1994 calendar year:

Service	High Cost-Sharing	Low Cost-Sharing	Combination
Primary health care	\$ 1,650	\$ 1,569	\$ 1,585
Prescription drugs	91	123	117
Mental health/ substance abuse	225	175	185
Dental	35	35	35
Vision/hearing	14	14	14
Preventive	65	54	56
Total	\$ 2,080	\$ 1,970	\$ 1,992

Since the above costs represent the premium rate for a "covered life," we need to recalculate the costs and convert them to adult and children costs to develop a four-tier rate structure. On average, a child costs around 50 percent the cost of an adult. Therefore, a single adult cost will be more than the above "per covered life" cost. Making these adjustments, the

following table provides these costs under a four-tier pricing structure using actuarially determined costs:

Family Category	High Cost-Sharing	Low Cost-Sharing	Combination
Single adult	\$ 2,440	\$ 2,312	\$ 2,337
Two adults	4,880	4,624	4,674
Adult + children	4,619	4,388	4,434
Family	6,946	6,591	6,662

Comparison with the Administration's Pricing

The table below compares the Hewitt Associates pricing with the pricing for the standard plan which the Administration described as preliminary and included in the publication *Health Security: The President's Report to the American People*, released on October 27.

Family Category	Administration Average Plan	Hewitt Associates			Combination
		High Cost-Sharing	Percent Difference	Low Cost-Sharing	
Single adult	\$ 1,932	\$ 2,440	+26%	\$ 2,312	\$ 2,337
Two adults	3,865	4,880	+26%	4,624	4,674
Adult + children	3,893	4,619	+19%	4,388	4,434
Family	4,360	6,946	+59%	6,591	6,662

Our cost estimates are higher than the published estimates by the Administration. However, if the Health Security Act were successful in reducing future health care increases to the rate of increase in the CPI, the costs of the standard package would eventually drop below what companies would be expected to pay based on current trend levels. Congress will have to

judge the likelihood of the Health Security Act being able to impose such stringent cost controls, and under what time frame this could be accomplished.

The above comparison also indicates that the current Administration pricing seems to subsidize the Family category more than the others. This is the reason our Family costs are 59 percent higher versus 19 to 26 percent higher for the other coverage categories.

A true comparison with the Administration's pricing is difficult to make because of internal inconsistencies in the various published descriptions of the way the plan would be priced. The statutory language and the *Health Security* book both describe a four-tier pricing structure for: single individuals, couples, single-parent households, and couples with children. Section 1011(c) of the Health Security Act says that "each of the following is a separate class of family enrollment" and lists "individual," "couple-only," "single parent," and "dual parent." Section 1531 then charges the National Health Board with establishing "for each of the classes of family enrollment" the "relative actuarial value of the comprehensive benefit package of the class of family enrollment" compared to the individual enrollment, with individual enrollment having a factor of one and married couples without children a factor of two. Accordingly, page 112 of the *Health Security* book gives the four prices shown in our comparison above. But then on page 113, it describes a three-tier pricing instead, and gives

three sets of prices instead of four.* The narrative description after that further confuses the issue by saying that couples without children and families would be charged the same amount, which may be read as a two-tier system." So we have used the statutory language because we are unsure what the Administration is really proposing in terms of the number of tiers.

The number of tiers of pricing is not just an academic issue. It directly lowers the price for those in some family statuses and raises the price for others, so Congress would have to decide on the number of tiers and which groups would subsidize others (e.g., couples without children subsidizing single parents and couples with children).

Regional Variations

The following table illustrates the large variation in expected 1994 costs (per single adult) for the standard package by geographic area. We developed these costs assuming the same health care utilization and opportunity for preferred provider rates that exist today in each area will also be true in the first year of health reform.

* "The employer share is a fixed amount. Employers only need to know whether their employee is buying a single, couple, or family policy to know what they will pay.

<u>Policy Type</u>	<u>Employer Share*</u>
Two-Parent Family with Children	\$2,479
Single Parent	\$2,479
Couple	\$2,125
Single Person	\$1,546
* 1994 Preliminary Estimates"	

Source: *Health Security*, p. 113.

" "For couples and families—who have two workers—employers will pay the same amount per worker.... There will be one employer price for family policies, regardless of whether both spouses work, or how many children they have."

Source: *Health Security*, p. 113.

Location	High Cost-Sharing	Low Cost-Sharing	Combination
New York, NY	\$ 3,388	\$ 3,400	\$ 3,398
Atlanta, GA	2,603	2,605	2,605
Charlotte, NC	1,766	1,803	1,796
Little Rock, AR	2,107	2,127	2,123
Chicago, IL	2,781	2,579	2,619
Houston, TX	3,125	3,068	3,079
Los Angeles, CA	4,181	3,684	3,783

Regional variations in plans can be subtle; however, they are quite important. HMO participation by area is a very good example. We have compiled some statistics, based on where employers are headquartered.

There are very dramatic differences amongst employers when observing what percentage of employees participate in HMOs. The following table captures the aggregate percent of employees who have elected coverage under a standard HMO option in 1992, for 801 companies in our database.

Percent of Employees in HMOs

Less than 10%	17%
10%-19%	25%
20%-29%	22%
30%-39%	16%
40%-49%	8%
50%-59%	7%
60% or more	5%
	<hr/> 100%

 (801 employers)

Regional variations are significant. HMOs have had tremendous success in enrolling participants in California and Minnesota. So, you would expect the percentage of employee populations enrolled in HMOs to be much higher in these two states. In fact, only 19 percent of employers in California offer the traditional indemnity medical plan as their main plan. Compare this to 75 percent of employers in Maryland, New Jersey, and Pennsylvania. Furthermore, 28 percent of employers in California have HMO participation by more than half of their enrollees versus 4 percent of employers in Maryland, New Jersey, and Pennsylvania and 2 percent in Texas.

Other plan features tend to have geographic differences too. In the state of Texas for example, more employers tend to have special plan limits for mental health and substance abuse care than the average employer in the country. Also, states that have high health care costs (e.g., the Northeast, California, Florida and Texas) tend to have higher plan deductibles and other copay amounts in order to maintain the same level of benefits paid as in other parts of the country. For example, 50 percent of Michigan's large employers have either no

deductible or a deductible of \$100 or less compared to 35 percent of large employers in California and 21 percent in Texas.

There are many other differences in plan provisions by region. Appendix C includes a summary of various plan provisions and their variations for a select group of states.

Conclusion

Mr. Chairman, these are our best estimates of the cost of the standard benefit package specified in the Health Security Act, based on the information currently available to us.

We have also given you the assumptions that we have used. If Congress were to change the assumptions, the price of the package would vary up or down. So it would be useful if, in your consideration of the legislation, you could have all the assumptions used by the Administration and by others put on the table for public discussion and assessment.

Estimating the financial impact of the benefit package should also include a breakdown of how much it would cost in the various regions of this country. As we have attempted to show, there can be strong differences between the national average and the regional prices.

Finally, we would suggest that no single number on the pricing will turn out to be exact. Rather, it is more likely that each number will fall within a range, and it would probably be prudent for Congress to use a range of optimistic and pessimistic assumptions to appreciate the true financial dimensions of the benefit package.

APPENDIX A**Plan Summary; Actuarial Methods and Assumptions**

The low cost-sharing option has been priced assuming today's level of provider discounts and expected utilization savings from the managed environment. We also added a factor for the out-of-network option. These discounts and savings vary by area. Our pricing assumes a gatekeeper arrangement with strong financial incentives for the primary care physicians. Again, if alliances can negotiate lower fees to begin with, the costs would be lower.

A possible result of regional alliance negotiations for both fee-for-service schedules and managed care discounts is that price differences between the two may narrow. This may result in lower fee-for-service costs relative to the lower cost-sharing managed care plans.

The pricing models used for this analysis are based on claims data collected for the 1990 and 1991 calendar years. They have been trended forward to represent expected covered expenses for the 1994 calendar year.

Health Security Act Plan Provisions

These are the three sets of cost-sharing options we used in our pricing, based on the October 27, 1993 version of the Act.

High Cost-Sharing Option

Plan Type	Fee-for-service
Plan deductible	\$200 individual/\$400 family
Coinsurance	80 percent
Out-of-pocket limit	\$1,500 individual/\$3,000 family
Prescription drugs	\$250 separate deductible; 80 percent coinsurance; subject to out-of-pocket limit
Mental health/ substance abuse	Inpatient: 80 percent after one-day deductible up to out-of-pocket limit; 30-day/episode maximum; 60-day/year maximum; nonresidential treatment up to 120 days; day maximums eliminated by 2001; Outpatient: 50 percent psychotherapy (80 percent in 2001); 30-visit maximum; 80 percent other; not counted toward out-of-pocket limit until 2001; visit maximum eliminated by 2001
Dental	Preventive and diagnostic at 100 percent; \$50 deductible and 60 percent coinsurance for restoration and interceptive orthodontia; all services for children under 18 initially (except emergency services for all ages); adult coverage added in year 2001 (without endodontic coverage)
Vision/hearing	80 percent coinsurance; eyeglasses limited to children
Preventive	Routine physical exams and specified testing at 100 percent

Low Cost-Sharing Option

Plan Type	Managed care (HMO type)
Office visits	\$10 copay, but at least 20 percent coinsurance for out-of-network services

Emergency room visits	\$25 copay (if not emergency medical condition)
Outpatient therapy	\$10 copay per visit
Prescription drugs	\$5 copay per prescription
Mental health/ substance abuse	Inpatient: 100 percent; 30-day/episode maximum; 60 day/year maximum; nonresidential treatment up to 120 days; day maximums eliminated by 2001; Outpatient: \$25 copay psychotherapy (\$10 in 2001); 30-visit maximum; \$10 copay other; not counted toward out-of-pocket limit until 2001; visit maximum eliminated by 2001
Dental	\$10 copay preventive, diagnostic, and restorative services for children under 18 initially (\$20 copay for space maintenance and interceptive orthodontia); adults added in year 2001 (without endodontic coverage)
Vision/hearing	\$10 copay per exam or for one set of eyeglasses; eyeglasses limited to children
Preventive	Routine physical exams and specified testing at 100 percent

Combination Cost-Sharing Option

The plan priced assumed a point-of-service type plan with the low cost-sharing option as the in-network benefit and the high cost-sharing plan as the out-of-network benefit.

Methods and Assumptions

Data Sources

The actuarial pricing models are based on data compiled from Hewitt Associates **Health Information/System™** database. The data represents roughly 8 million life years, both adult and child, for the 1990 and 1991 calendar years. The claim volume is over \$11 billion, covering all categories of medical expense. Data was reviewed for reasonable allocations by service category (e.g., inpatient, surgical, drugs, mental health), and employee relationship (e.g., employee, spouse, and children).

Pricing Models

The pricing models developed by this data are structured in the following functional components:

- Primary health care benefits with deductible, coinsurance, other copay, and out-of-pocket variables;
- Prescription drugs (if not included above);
- Mental health and substance abuse (if not included above); and
- Lifestyle-related benefits.

The above models are distinct components of the system but are interrelated with each other. That is, the level of covered expenses used in the primary pricing model influences the level of benefits in the other models.

The models are set to develop prices for the 1993 calendar year. Costs shown in this report used 1994 as the basis for costs. Covered expenses were trended forward from 1993 at a 10 percent rate.

Adjustments for Regional Alliance

The pricing model developed is based on claims data for employers with well-established health plans. The health care utilization for regional alliances will differ from employer plan experience due to:

- Expanded covered group (Medicaid and uninsured primarily);

- Elimination of cost shifting due to uncompensated care and Medicaid;
- Different demographic composition of insured units (single, family coverages, age, and sex); and
- Different geographic areas, on average (our database companies tend to be in metropolitan areas).

We have adjusted our costs to reflect the above differences. The following assumptions were used:

1. Expanded covered group Assumed additional 30 percent currently with Medicaid coverage and the uninsured, on average, cost 20 percent more than the current insured population. Costs loaded 6 percent.
2. Elimination of cost shifting Assumed 5 percent of total health care costs will be reduced due to elimination of cost shifting for all uncompensated care and a large portion of current Medicaid cost shifting.
3. Demographic composition U.S. population assumptions used to develop 4-tier family rates (see below).
4. Geographic differences Cost adjusted based on total U.S. population relative to database population. Costs reduced by 2 percent.

Commentary on Adjustments

We have factored in savings of 1.5 percent for elimination of uncompensated care and another 3.5 percent for elimination of cost shifting from Medicaid, for a total of 5 percent. We are aware that the Administration argues that cost shifting would reduce costs to employers by 20 to 25 percent. We have used a more conservative estimate because we think that it is unlikely that a reduction of that magnitude could be achieved in the first few years of the program. Over a longer period of time, perhaps such savings could be achieved by cost controls and elimination additional of cost shifting from Medicare. The costs provided in our testimony today reflects initial costs of the program; and therefore, we feel that it is unrealistic to expect a 20 to 25 percent reduction in fees.

The level of cost-shifting represented here is on an overall basis. The degree to which hospitals must reallocate charges depends on the amount of uncompensated care they provide. The American Hospital Association has noted that 5 percent of hospitals provide over a third of all uncompensated care. Therefore, the level of cost-shifting experienced by an employer's medical plan will vary depending on which hospitals are used by employees.

On the physician side, the same sort of pressures apply. Medicare and Medicaid are not increasing payment rates fast enough to cover increasing costs. In addition, a greater proportion of a doctor's total income is coming from sources such as HMOs and PPOs. These organizations are also marginally holding down the rates of increase in acceptable charges. Therefore physicians need to recoup lost earnings in some fashion if they are to maintain a steady income. Data indicates that overall physician income is increasingly marginally. However, charges to private payors do not seem to be increasing faster than expenses. It

would appear, and data supports, that utilization of physician services is increasing. In this manner, doctors can recoup lost revenue.

Various experts concur that the dynamics of physician cost shifting are different than those in the hospital sector. First, because profit margins are higher, doctors are still recovering the costs of doing business from all payment sources (i.e., doctors only need to recover lost profit, not pay bills). Second, most of a hospital's costs are fixed, whereas doctors can react more quickly to changes in circumstances. (Therefore, they do not *need* to cost-shift, they have more options.) Third, unlike a hospital, doctors can increase the number of patients they see, or invest in diagnostic equipment, etc. to earn more income.

While unbundling, upcoding, and increased utilization may be attributable to physicians attempting to recover lost income due to discounts, we cannot factor this increase out of overall utilization increases.

Demographic Composition

The following demographic composition from the *March 1992 Current Population Survey* was assumed for the different rate structures by coverage category:

Category	Percent
One adult	38.0%
Two adults	25.0%
Adult and children	10.0%
Two adults and children	27.0%

Administrative Expenses

We have assumed that administrative expenses will be equal to 10 percent of incurred claims. These expenses include 1.5 percent for the health infrastructure and 2.5 percent for regional alliance administration as specified by the Health Security Act. We have also included 4.0 percent for claims administration and 2.0 percent for other reporting and administration costs of the health plans.

APPENDIX B**High Cost-Sharing Plan Relative Value**

Hewitt Associates maintains a database of plan provisions covering the salaried employees of large employers in the United States. This allows us to determine the value of all benefit programs offered by these employers. We used this database to compare the high cost-sharing plan option to the values of the plans that were run in 1993. This included values for 487 companies in the industries listed below.

We found that the high cost-sharing plan ranked 227th out of 488 in terms of relative value, with 1 being the highest valued plan. This is the 12th percentile of all companies. This lower ranking is primarily because the Health Security Act plan does not include non-emergency adult dental benefits until the year 2001. If we compare medical plan benefits only, then the relative value of the Health Security Act plan rises to the 53rd percentile (227th out of 488).

Accounting/consulting	2
Aerospace	19
Apparel/textiles	3
Automotive	42
Banking/finance/insurance	17
Building materials	4
Chemicals	29
Communications	10
Electronics	32
Energy/oil/mining	36
Engineering/construction	15
Food and beverage	39
Forest products	24
Household products	2
Industrial equipment	14
Information processing	21
Leisure/entertainment	6
Medical products	8
Metals/steel	4
Multicompanies	7
Personal products	11
Pharmaceuticals	16
Publishing/printing	10
Real estate	13
Research/testing/development	6
Retail distribution	16
Supermarkets/wholesalers	1
Tobacco	3
Transportation	3
Utilities	27
Other	47
Total	487

Summary of Plan Provisions
Major Employers' Salaried Plans in 1992
Hewitt Associates SpecBook
(by Headquarters Location of Employer)

General Industry	California (n=97)	Michigan (n=36)	Pennsylvania/ New Jersey/ Maryland (n=117)	Louisiana/ Texas (n=39)	Washington (n=13)	Wisconsin (n=39)	Georgia (n=16)	Connecticut (n=26)	Iowa/ Nebraska/ Kansas (n=18)
TYPE OF PLAN									
Traditional indemnity	57%	64%	75%	51%	69%	77%	63%	76%	38%
Indemnity + PPO	9%	17%	6%	18%	1%	5%	12%	16%	16%
Indemnity + POS/HMO	2%	2%	2%	5%	31%	23%	6%	2%	56%
PPO	24%	17%	10%	27%			19%	15%	
POS/HMO	4%	1%	3%	5%					
Other combinations	1%	1%	1%	2%					
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%
HMO PARTICIPATION									
Less than 10%									
10% - 19%	17%	14%	26%	23%	11%	5%	11%	15%	18%
20% - 29%	25%	21%	26%	26%	22%	13%	34%	22%	25%
30% - 39%	22%	17%	25%	30%	25%	13%	22%	22%	25%
40% - 49%	16%	17%	9%	16%	45%	26%	22%	22%	38%
50% - 59%	20%	10%	7%	3%		17%	11%	8%	
60% - 69%	17%	7%	3%	2%	9%			8%	12%
70% or more	2%		1%		17%				12%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%
NUMBER OF MEDICAL PLANS									
One Plan	49%	36%	46%	54%	65%	67%	56%	49%	44%
Two Plans	19%	22%	17%	15%	15%	20%	19%	15%	11%
Three Plans	23%	25%	27%	19%	23%	10%	13%	24%	28%
Four Plans	8%	6%	6%	11%			6%	12%	17%
Five or More Plans	1%	8%	2%	1%		3%			
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%
INDIVIDUAL DEDUCTIBLE									
No Deductible	13%	14%	13%	14%	38%	10%	44%	6%	6%
\$100 or less	14%	36%	13%	16%	23%	21%	12%	15%	11%
\$150	16%	14%	20%	14%	22%	23%	19%	12%	22%
\$200	23%	26%	13%	24%	8%	31%	28%	28%	11%
\$250	12%	8%	13%	10%	8%	5%	25%	9%	22%
\$300 or more	11%	8%	9%	22%	8%	2%	12%	12%	11%
Varies by pay	10%	8%	14%	6%		5%	18%	18%	6%
Other	1%								
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%

Summary of Plan Provisions Major Employers' Salaried Plans in 1992 Hewitt Associates' SpecBook (by Headquarters Location of Employer)										
	General Industry (n=607)	California (n=42)	Michigan (n=30)	Pennsylvania/ New Jersey/ Maryland (n=102)	Louisiana/ Texas (n=76)	Washington (n=12)	Wisconsin (n=34)	Georgia (n=16)	Connecticut (n=31)	Iowa/ Nebraska/ Kansas (n=18)
OUT-OF-POCKET LIMIT										
Less than \$500	5%	6%	13%	4%	1%		6%	6%	3%	11%
\$500 - \$999	5%	5%	17%	17%	7%	33%	6%	6%	6%	6%
\$1,000 - \$1,999	10%	10%	10%	10%	10%	20%	20%	19%	20%	27%
\$2,000 - \$3,999	21%	21%	20%	21%	24%	17%	32%	25%	13%	6%
\$4,000 - \$5,999	23%	23%	13%	18%	33%	33%	12%	30%	16%	33%
\$6,000 - \$7,999	7%	16%	4%	8%	13%	8%		6%	10%	6%
\$8,000 - \$9,999	7%	10%		4%	16%				3%	
\$10,000 or More	1%			1%	1%		3%			
Based on pay	10%	7%		12%	1%		3%		25%	11%
Family limit only	4%	4%	13%		4%	9%	3%			
Other (e.g., varies by years of service)	1%			100%	1%	100%	3%	100%	100%	100%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
INPATIENT LIMITS FOR MENTAL HEALTH & SUBSTANCE ABUSE	(n=1,025)	(n=97)	(n=36)	(n=117)	(n=84)	(n=13)	(n=39)	(n=16)	(n=33)	(n=18)
No special limits	10%	4%	11%	16%	5%		13%	31%	18%	5%
Limits for both mental health and substance abuse	78%	88%	78%	70%	79%	69%	77%	56%	67%	78%
Special limits for mental health only, none for substance abuse	2%	2%	3%	4%	3%		3%			
Special limits for substance abuse only, none for mental health	7%	4%	5%	10%	10%	15%	5%	13%	15%	17%
Other	1%	2%	3%	3%	3%	8%	2%			
Not covered	1%									
Data not available	1%									
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
OUTPATIENT LIMITS FOR MENTAL HEALTH & SUBSTANCE ABUSE	(n=1,025)	(n=97)	(n=36)	(n=117)	(n=84)	(n=13)	(n=39)	(n=16)	(n=33)	(n=18)
No special limits	3%			3%	2%		5%	6%	3%	
Limits for both mental health and substance abuse	87%	93%	89%	84%	87%	69%	90%	88%	77%	94%
Special limits for mental health only, none for substance abuse	5%	1%	8%	8%	6%		3%	6%	12%	
Special limits for substance abuse only, none for mental health	1%			2%	1%					6%
Other	3%	3%	3%	3%	4%	23%	2%		6%	
Not covered	1%					8%				
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Summary of Plan Provisions
Major Employers' Salaried Plans in 1992
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(by Headquarters Location of Employer)

	General Industry (n=1,025)	California (n=97)	Michigan (n=36)	Pennsylvania/ New Jersey/ Maryland (n=117)	Louisiana/ Texas (n=84)	Washington (n=13)	Wisconsin (n=39)	Georgia (n=16)	Connecticut (n=33)	Iowa/ Nebraska/ Kansas (n=18)
PRESCRIPTION DRUG COVERAGE										
Comprehensive Plan	51%	41%	42%	51%	54%	54%	67%	63%	58%	44%
- with generic incentive	4%	1%	1%	4%	10%	8%	8%	13%	3%	11%
- with mail order incentive	8%	4%	11%	7%	7%	7%	8%	8%	6%	
- with combination of generic and mail order incentives	5%	5%		7%	2%	8%	5%	6%	15%	11%
Drug Card Plan (100% after co-pay)	8%	18%	31%	10%	6%	15%	2%	6%	3%	
- with generic incentive	2%	11%	5%	5%	7%	8%	8%	6%	6%	11%
- with mail order incentive										
- with combination of generic and mail order incentives	4%	1%	8%	5%	9%	7%	2%	6%	6%	6%
Depends on medical option selected	10%	17%		11%	5%				3%	17%
Other		1%								
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
DENTAL PLAN PREVALENCE	(n=1,026)	(n=96)	(n=36)	(n=117)	(n=84)	(n=13)	(n=39)	(n=16)	(n=33)	(n=18)
Have dental plan:										
- based on percentage of charges	83%	93%	86%	85%	92%	69%	89%	68%	76%	88%
- based on schedule	6%	2%	8%	8%	1%	23%	5%	13%	15%	6%
- based on a combination	3%	1%	6%	3%	4%	8%	3%	13%	6%	
Spending account only	3%	3%		3%	2%				3%	
Depends on plan selected	2%	3%		1%	1%		3%			
No plan	3%		100%	100%	100%	100%	100%	100%	100%	6%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
VISION PLAN PREVALENCE	(n=1,026)	(n=97)	(n=36)	(n=117)	(n=84)	(n=13)	(n=39)	(n=16)	(n=33)	(n=18)
Have vision plan	32%	58%	39%	28%	35%	77%	54%	37%	27%	28%
Spending account only	42%	24%	47%	45%	32%	8%	28%	38%	55%	50%
Depends on plan selected	1%	3%	3%	1%	1%					
No plan	25%	18%	100%	27%	32%	15%	18%	25%	18%	22%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
HEARING PLAN PREVALENCE	(n=1,026)	(n=97)	(n=36)	(n=117)	(n=84)	(n=13)	(n=39)	(n=16)	(n=33)	(n=18)
Have hearing plan	9%	11%	22%	9%	11%	23%	8%	12%	9%	11%
Spending account only	49%	40%	47%	51%	37%	23%	38%	44%	58%	50%
Depends on plan selected										
No plan	42%	49%	31%	40%	52%	54%	54%	44%	33%	39%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Mr. WAXMAN. Thank you. Mr. Abramowitz?

STATEMENT OF KENNETH S. ABRAMOWITZ

Mr. ABRAMOWITZ. Thank you very much, Mr. Chairman, for inviting me here today. I am a health care analyst for Sanford C. Bernstein and Co., Inc. I advise virtually all the major banks and mutual funds in the country and in Europe as to how to invest money in health care. We represent about 50 percent of the stock market.

During the last 12 years—I have been on Wall Street for 15 years. During the last 12 years, I have been voted the number one health care analyst for 10 out of the past 12 years and I am the author of a 200-page report on the future of health care which I would be pleased to make available to you and anybody on the committee who wants it.

I am known for my objectivity and frankness and I will treat you with the same courtesy.

I would like to summarize my text in 1 minute to summarize where the system is going today, the absence of health care reform, and then spend the remaining 4 minutes on my analysis of the Health Security Act and its impact on investors.

In terms of summarizing the statement, we have a big revolution going on in health care today. We have two big revolutions. One is the movement to HMO's away from insurance carriers. Today, 25 percent of the privately insured population is a member of an HMO. By the year 2000, it will easily be 50 percent of the population without doing anything. The HMO's are replacing the insurance companies and they are replacing them fast.

A typical HMO is experiencing 5 percent cost growth. A typical insurance company experiences 10 or 15 percent cost growth. The insurance industry is simply not competitive anymore. The HMO's are going to replace the insurance carriers.

The second big trend is pharmacy benefit management companies, companies like medicine cost containment which was recently purchased by Merck, are growing very rapidly. Today, 20 percent of the population is covered by these companies. By the year 2000, I think 70 percent of the people will be covered by these companies, who are feverishly working to control drug inflation and doing a very good job at it.

In fact, they are doing such a good job that investors have had a very difficult time making money in drug stocks for the last year, as a result.

Because of these dual revolutions in the private sector, inflation is slowing fast from 10 percent down to 6 to 8 percent. When you see inflation numbers over the next year, you will be amazed how low they are. Because I cover these companies, I write about Johnson & Johnson and in the hospital companies, Columbia. Everybody is struggling to make their earnings estimates and revenue estimates. In other words, the private sector solution is at hand. Health care will never reach 27 percent of the GNP. It is now 14. It will go to 15 or 16 grudgingly by the year 2000 if you don't do anything.

I would like to spend the remaining 4 minutes on analyzing the Health Security Act and its impact on investors. If you go to page

5 of my handout, I just want to show how investors react to certain issues. For example, number 2, finding a modest employer mandate is imperative for hospitals, because their bad debts are 6 percent. If we have an employer mandate, it would go to 3. That is positive for hospitals.

Encouraging employers to pay 80 percent of an average plan is very positive for HMO's, and I think will move 70 percent of the people into HMO's by the year 2000. I think the President deserves a lot of credit for having the guts to put something like this in a plan. A typical HMO charges \$5,000 a year. A typical PPO is \$5,000. An insurance company is \$6,000.

In that example, the average plan is \$5,000. If the employer pays 80 percent of \$5,000, that is \$4,000. In other words from the employee's point of view, they will be able to join an HMO for free but have to pay roughly a \$1,000 to join a PPO or \$1,000 to join an insurance plan. That is wonderful health care policy.

By charging everybody \$1,000 or \$2,000, if they don't join an HMO, I think it will encourage 70 percent of people to join HMO's by the year 2000. And number 8, HMO's already abide by small case reform. They are already community rated and already they cannot disallow insurance to people for preexisting exemptions. The insurance industry is the one who will be penalized by this because they don't play by these rules. The HMO's already do. So this was also a very big positive for HMO's.

Just summarizing, just a couple of other features, if I could have another 30 seconds, looking at number 13, subsidizing the employer mandate at 3 to 8 percent of wages is actually a negative for HMO's and hospitals. The reason is that according to my numbers, the plan is about \$50 to \$100 billion underfinanced. And I don't think you are going to want to raise taxes in 5 years to pay for it. Therefore, you will have no choice but to underpay HMO's and hospitals. That would be very serious.

Also, I just wanted to mention number 20, if the Health Board is assigned to review drug pricing, it will very seriously impact access to capital for the drug industry. Today there are maybe a thousand biotechnology companies who will run out of money in 3 years if they don't get another round and another round.

So I think that if this goes through, I could see 50 to 75 percent of all biotechnology companies go bankrupt within 5 or 10 years, which would be very serious. It is actually a positive for the hospital industry because if those people don't get those drugs and they show up in the hospital instead, it actually helps the hospital industry.

As a final point, I just wanted to mention that essentially what is going on here is the desire to take control of the health care industry by the government, and in effect have the government decide what insurance companies, what HMO's and drug companies will make as an adequate rate of return, with a plan that is underfinanced that you won't want to raise taxes for, and therefore will in effect cause virtually every health care company to operate with no profitability.

If you want to do that, I would advise my clients if I thought this plan were to pass, I would advise them to sell all their health care stocks and all their health care bonds. Now, I only represent 50

percent of the market, so maybe the other 50 will be there. But if you want to nationalize the health care system, don't expect the capital to be there.

Thank you very much.

[The prepared statement and charts of Mr. Abramowitz follow:]

STATEMENT OF KENNETH S. ABRAMOWITZ

Market-based forces are dramatically encouraging the growth of HMOs, as shown in Exhibit 1. HMOs now service nearly 50 million lives and are growing 10% annually. By 1997, over 70 million will be covered by HMOs. The major driving force behind HMOs is their ability to hold cost growth to levels 5% below that of traditional insurance carriers. A typical HMO is now a 30-40% better value than a comparable insurance plan. Consequently, as shown on page 2, HMOs will inevitably replace traditional insurance carriers as the dominant mode of insurance over the next 10 years. However, HMOs will play only a modest role in the Medicare population, as shown on page 3, because of insufficient incentives for beneficiaries to use HMOs.

As shown on page 4, the Health Security Act would both positively and negatively impact managed care companies such as HMOs, PPOs, and well-positioned insurance carriers. Such companies would benefit from an employer mandate to provide cost-effective health insurance and small group reform to force community rating and disallow pre-existing exemptions for all, which HMOs already abide by. HMOs would particularly benefit from a mandate that employers contribute 80% of an average plan, because HMOs can easily be 20% less costly than an average plan. Consequently most employees will be able to join an HMO for free, but may well have to pay \$500-2,500 out-of-pocket to join a PPO or a traditional insurance carrier.

On the other hand, some aspects of the Health Security Act would be negative for HMOs. For example, offering drug benefits to all Medicare beneficiaries reduces the incentive to join HMOs. Subsidizing low interest rate loans to hospitals to establish their own HMOs would offer these competitors an undue advantage. Mandatory Health Alliance enrollment for all employers with less than 5,000 employees will sever HMO relationships with corporate benefit managers and force HMOs to become consumer marketing companies to 150 million individuals. No employer insurance tax cap incents people to stay in expensive, poorly-managed plans. Particularly hurting HMOs would be the subsidizing of the employer mandate, if financing were to be insufficient and lead to arbitrarily lower rates. Price controls on fee-for-service physicians would disincent people from joining HMOs by making traditional insurance temporarily viable. Forcing HMOs to offer point-of-service options with no incentives to use primary care gatekeepers would impair cost-containment capabilities, quality control, and medical outcome studies.

If all these negative aspects were to pass into legislation, investors would question the ability of HMOs to continue growing membership, revenues, and earnings on a dependable basis, determined by market-place forces. Consequently, stock prices would quickly fall, access to capital would subside and management confidence and willingness to invest would decline. The country will have missed a golden opportunity to contain costs through private-sector competition.

Exhibit 1

HMO Census by Company (Millions of Enrollees at Year-End) (1)

	1987	1988	1989	1990	1991	1992	1993E	1994E	1995E	1996E	1997E
Kaiser Permanente (Oakland, CA)	3.1	3.6	6.3	6.8	6.6	6.6	6.9	7.2	7.6	8.0	8.5
Blue Cross (Chicago, IL)	4.5	4.5	4.7	4.8	5.1	6.2	6.7	7.4	8.0	9.0	10.0
Prudential (Newark, NJ)	1.2	1.8	1.7	1.8	2.2	2.9	3.4	4.0	4.6	5.3	6.0
CIGNA Healthplan (Hartford, CT)	1.1	1.4	1.5	2.1	2.1	2.3	2.8	2.8	3.2	3.7	4.3
United HealthCare (Minneapolis, MN)	1.5	1.0	1.0	1.2	1.4	1.7	2.4	2.6	2.8	3.0	3.5
Humana (Louisville, KY)	0.5	0.7	0.8	1.0	1.5	1.5	1.5	1.7	1.9	2.1	2.4
U.S. Healthcare (Blue Bell, PA)	0.8	0.9	1.0	1.1	1.2	1.4	1.6	1.8	2.0	2.2	2.6
Aetna (Hartford, CT)	0.5	0.8	1.5	1.5	1.3	1.5	1.5	1.4	1.7	2.0	2.5
HIP (New York, NY)	1.0	1.0	1.1	1.1	1.1	1.1	1.2	1.3	1.4	1.5	1.6
PacificCare (Cypress, CA)	0.2	0.3	0.4	0.7	0.8	1.0	1.3	1.2	1.3	1.4	1.5
Health Net (Van Nuys, CA)	0.5	0.6	0.7	0.8	0.8	0.8	1.2	1.4	1.5	1.7	1.8
Status (New York, NY)	0.3	0.3	0.6	0.7	0.8	0.8	0.9	1.0	1.1	1.2	1.3
Metropolitan Life (New York, NY)	0.3	0.4	0.5	0.6	1.0	1.5	1.7	2.2	2.7	3.4	4.0
FHP (Fountain Valley, CA)	0.3	0.4	0.5	0.6	0.6	0.8	0.9	1.0	1.2	1.3	1.4
TenetCare (Crescent, CA)	0.2	0.2	0.2	0.2	0.6	0.6	0.8	0.9	1.0	1.1	1.2
Harvard Community Health (Boston, MA)	0.4	0.4	0.5	0.5	0.5	0.5	0.6	0.7	0.7	0.8	0.8
Travelers (Hartford, CT)	0.1	0.1	0.1	0.2	0.5	0.5	0.9	1.2	1.4	1.5	1.6
Henry Ford (Detroit, MI)	0.2	0.4	0.5	0.5	0.5	0.5	0.6	0.7	0.8	0.9	1.0
HealthPartners (Minneapolis, MN)	0.2	0.2	0.2	0.2	0.2	0.2	0.6	0.6	0.6	0.7	0.7
WellPoint (Woodland Hills, CA)	0.1	0.1	0.2	0.3	0.4	0.5	0.5	0.6	0.7	0.8	0.9
Group Health of Puget Sound (Seattle, WA)	0.3	0.4	0.4	0.4	0.5	0.6	0.6	0.6	0.7	0.7	0.8
Mid Atlantic (Rockville, MD)	0.1	0.1	0.1	0.3	0.4	0.4	0.5	0.5	0.6	0.7	0.8
Foundation Health (Sacramento, CA)	0.3	0.4	0.4	0.5	0.5	0.4	0.5	0.5	0.6	0.7	0.8
Corventy (Nashville, TN)	-	0.2	0.2	0.3	0.5	0.4	0.5	0.6	0.7	0.8	0.9
Principal Health (Rockville, MD)	-	-	0.1	0.2	0.2	0.3	0.4	0.5	0.6	0.7	0.8
Physician Corp. of America (Miami, FL)	-	0.1	0.1	0.1	0.2	0.5	0.4	0.5	0.6	0.7	0.8
HealthSource (Concord, NH)	-	0.1	0.1	0.2	0.2	0.5	0.3	0.4	0.5	0.6	0.7
Integrarep (Tucson, AZ)	-	0.1	0.2	0.2	0.2	0.5	0.3	0.4	0.5	0.6	0.7
Maricopa (Los Angeles, CA)	2.3	0.8	0.4	0.3	0.3	0.5	0.3	0.3	0.4	0.4	0.5
CareAmerica (Chesworth, CA)	-	-	0.1	0.2	0.2	0.5	0.3	0.4	0.5	0.6	0.7
Sierra Health (Las Vegas, NV)	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.3
Ramsey-HMO (Miami, FL)	-	-	-	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.3
Family Health (Milwaukee, WI)	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2
Oxford (Durham, CT)	-	-	-	0.1	0.1	0.1	0.2	0.2	0.3	0.3	0.4
Pris (Trenton, CT)	-	-	0.1	0.1	0.1	0.1	0.2	0.2	0.3	0.3	0.3
Qual-Med (Florida, CO)	-	-	0.1	0.1	0.2	0.3	-	-	-	-	-
HMO America (Chicago, IL)	0.1	0.2	0.2	0.2	0.2	0.3	-	-	-	-	-
Other	0.2	0.9	0.5	0.9	0.1	7.8	7.3	6.5	6.8	6.7	6.5
Total	30.5	31.4	38.0	38.0	41.0	48.8	49.3	54.3	60.5	64.8	72.5
% Increase	14%	9%	5%	5%	8%	10%	10%	10%	10%	10%	10%
Members: % of Plans	600	600	390	380	380	545	560	560	580	580	585
Members (000)/Plan	47	56	89	88	76	82	92	102	109	117	124
Price Increase - HMO Industry	5%	10%	17%	16%	13%	12%	9%	7%	8%	8%	6%
- Insurance Industry	8%	20%	27%	20%	17%	17%	14%	12%	10%	10%	11%
- HMO Value Advantage	2%	12%	22%	26%	30%	30%	40%	40%	50%	50%	60%

(1) Includes gate-keeper selected point-of-service plans.
Source: Interstudy, CHAA, and Bureau estimates.

Exhibit 2

Private Pay Segmentation Hospital Patient Days Per 1,000 Population

	1987	1988	1989	1990	1991	1992	1993E	1994E	1995E	1997E	2000E	2100E
Fee-For-Service	695	680	670	640	610	580	570	560	550	530	500	450
Fee-For-Service-Managed(1)	580	575	550	540	530	515	500	490	480	460	430	410
Fee-For-Service-FFO(2)	580	575	550	525	500	475	480	430	410	400	370	400
HMO(3)	575	565	565	570	560	550	540	530	525	520	530	550
Weighted Avg. Patient Days	600	590	575	550	530	510	485	465	445	415	400	370
% Increase	(1) %	(2) %	(3) %	(4) %	(4) %	(4) %	(5) %	(4) %	(4) %	(5) %	(1) %	(1) %

Private Pay Segmentation % of Population in Each Tier

Fee-For-Service	57 %	48 %	41 %	33 %	24 %	18 %	15 %	12 %	10 %	7 %	5 %	3 %	0 %
Fee-For-Service-Managed(1)	15	20	23	24	25	23	21	19	16	14	12	7	5
Fee-For-Service-FFO(2)	13	16	20	25	30	35	38	41	44	46	48	45	25
HMO-IPA(3)	9	10	11	12	13	15	16	17	18	20	21	28	35
- Group/Staff	5	6	6	7	8	9	10	11	12	13	14	17	35
Total	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %

Notes: HMOs as % of Private

Population

Uninsured Population

(1) - Assumes hospital pre-admission certification.

(2) - Assumes both pre-admission certification and provider discounts

(3) - Includes open HMOs with point-of-service options.

Source: AHA, Blue Cross, IntelliStudy, and Berrington estimates.

Table 1.3

**Medicare Segmentation
Hospital Patient Days Per 1,000 Population**

	1987	1988	1989	1990	1991	1992	1993E	1994E	1995E	1997E	2002E	2100E
Fee-For-Service	-	-	-	-	-	-	-	-	-	-	-	-
Fee-For-Service-Managed	3,560	3,360	3,360	3,260	3,250	3,270	3,250	3,215	3,100	3,170	3,130	2,800
Fee-For-Service-PPO	-	-	-	-	-	-	-	-	2,700	2,600	2,500	2,200
HMO	1,800	1,780	1,725	1,700	1,675	1,660	1,610	1,520	1,430	1,450	1,300	1,300
Weighted Avg Patient Days	3,180	3,130	3,130	3,130	3,130	3,160	3,120	3,075	3,000	2,970	2,880	2,620
% Increase	(1) %	(1) %	0 %	0 %	(1) %	1 %	(1) %	(1) %	(1) %	(1) %	(1) %	(1) %

**Medicare Segmentation
% of Population in Each Tier**

Fee-For-Service	- %	- %	- %	- %	- %	- %	- %	- %	- %	- %	- %	- %
Fee-For-Service-Managed(1)	94	94	94	94	94	93	92	91	89	87	85	60
Fee-For-Service-PPO	-	-	-	-	-	-	-	-	1	2	3	5
HMO	6	6	6	6	6	7	8	9	10	11	12	30
Total	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %

(1) - Reflects Medicare's establishment of peer review organizations (PROs).

Source: HCFA, InterStudy, and Research estimates.

Exhibit 4**Analysis Of The Health Security Act**

(P= Positive, N=Negative)

	Impact		
	HMOs	Drugs	Hospitals
Reasonable			
1. Defining standardized benefits package, emphasizing prevention	P	-	-
2. Imposing some modest employer mandate	P	P	PP
3. Encouraging employers to contribute 80% of the average plan	PP	N	N
4. Means testing Part B Medicare premiums	P	-	-
5. Raising sin taxes significantly	-	-	N
6. Imposing standard claims form	-	-	-
7. Trying to increase the supply of primary care doctors	P	-	-
8. Small group reform: Forcing community rating, disallowing pre-existing exemptions	PP	-	N
Unreasonable			
9. Offering unmanaged Medicare drug benefits, only 25% financed by the beneficiaries	N	NN	-
10. Massive Medicare and Medicaid reimbursement cuts	N	N	NN
11. Subsidizing loans to hospitals and physicians who establish HMO	N	-	P
12. Setting up Health Alliances without trying first to reform existing insurance brokers	N	N	N
13. Subsidizing the employer mandate at 3-3% of wages for all corporations in the Health Alliances	NN	N	NN
14. Mandatory Health Alliance enrollment for all employers with less than 5,000 employees	N	N	N
15. No employer or employee insurance tax cap for those who buy expensive plans subsidizes excessive consumption	N	P	P
16. Assessing health plans to pay into a guaranty fund penalizes well-managed HMOs and encourages self-insurance	N	P	P
Fantasy			
17. Offering largely unfunded financial subsidies to 90% of the population, including non-Medicare retirees, will burden the government with another unsustainable benefit responsibility	N	N	N
18. Global budgets, set at arbitrary levels, grown in line with GDP will eventually increase morbidity and mortality	P/N	N	N
19. VA and DOD hospital systems are largely redundant, but not downsized or closed	P	-	N
20. National Health Board to review drug pricing will stifle innovation	-	NN	P
21. A government-imposed fee schedule for fee-for-service doctors with limited balance billing will lead to gross underpayments and less talented physicians and may be unconstitutional	NN	-	N
22. Forcing HMOs to offer a point-of-service option with no incentives to use primary care gatekeeper	NN	P	P
23. Allowing states to have the option of adopting a single payor system can lead to massive provider underpayments	NN	NN	NN
24. No major systemic malpractice reform will allow the lawyers who designed the plan to emerge unscathed	-	-	-

Mr. WAXMAN. Thank you for your testimony.

Let me start off with questions, one for Dr. Wilensky and Mr. Abramowitz. Both of you seem to have reservations about the way the President is proposing to finance his health care reform plan. I assume that both of you are also supportive of assuring that all Americans have coverage for health benefits.

Do you have any concrete alternatives for us this morning as to how we are going to pay for universal coverage for health benefits by January 1, 1998, as the President has proposed?

Mr. ABRAMOWITZ. Yes, I think there are other alternatives. I actually happen to agree with the concept of an employer mandate. I think the time has come for the employers to be responsible for their employees. I don't have any problem with the employer mandate. The only problem I have with it is I would redefine it.

In other words, instead of starting off for the 15 percent of people who don't have health insurance with an employer mandate to provide full health insurance, I would instead quantify the employer mandate.

For example, I would start off and say, all employers not providing health insurance, those 1 percent must provide a minimum of \$500 contribution to health insurance for their employees. The employees can supplement it. But at least everyone will be guaranteed \$500. That would be enough to buy a not very good, high deductible insurance policy, which is not the answer but at least it is a start, and then I would raise the \$500—

Mr. WAXMAN. What kind of start would that be for a low-income employee in a small business?

Mr. ABRAMOWITZ. You see what will happen is if the person shows up at the hospital and the hospital gives them a bill for \$20,000, in that example, if it is a \$10,000 deductible, the hospital will get \$10,000, of course, from the insurance company. They will just eat the other \$10,000. In other words, that person is not—

Mr. WAXMAN. He has got to be sick enough for the hospital to take in and stabilize. Otherwise, they will tell him to leave and go to a public hospital, wouldn't they?

Mr. ABRAMOWITZ. Sure. Remember, most hospitals take people in in an emergency. There won't be that problem. The problem is really on the primary care. In other words, they won't be getting the vaccinations they will be getting. I am not proud of it at all.

I am saying if we start at \$500 and raise it \$500 a year for 5 to 7 years in lieu of minimum wage increases—by the way, in 5 to 7 years, they will have an insurance policy that we will be proud of. Unfortunately, they won't be one we will be proud of during that interim as we ramp it up.

But by doing that, we won't be forcing the government to come up with subsidies when it has no money. I am not happy with it. I am just saying it is better than what is being proposed.

Mr. WAXMAN. Do you minimize the idea of cost shifts, which means those who have insurance will be paying far more for access to care when they don't have insurance?

Mr. ABRAMOWITZ. The whole system works on cost shifting. In this example, if we go to the hospital, we are paying for the people who aren't. So if they are paying a little bit by that deductible, it would actually slightly reduce the costs of health care for the other

85 percent of us who would have a little less cost shifting to pay for as a result.

Mr. WAXMAN. Dr. Wilensky, what is your alternative for universal coverage?

Ms. WILENSKY. I very much support universal coverage. I think we need to reduce some of the benefits that have been promised, in particular the early retiree benefit is one that not only has the potential for being explosive in cost, but is a very questionable policy for an aging society with a low birth rate. To start is to say I would like to scale back some of the benefits that have been promised. That will take away some of the pressure that is gone on.

The second part of what I would propose, and my concern in particular is I am making sure we have adequate subsidies for the lowest income population. That is not all the uninsured, but it is the uninsured I would like to fold in earliest. The areas I would like to are three.

The first is, I think disproportionate share spending is a block of money that ought to go for that purpose. That is not—that is why when I commented on that, I indicated that was not a particular concern. And I would like to see more flexibility being given to the States as to how that money is used.

The second, although I know the politics of this are difficult, is a tax cap. I do think that we have large amounts of Federal subsidies being devoted to higher income individuals, and because of the increased marginal tax rates that were in the economic plan, that has made that problem even more of an equity problem than it was in the past.

In the third place, I think we can do some Medicare reductions. I think this \$124 billion, that is a difficulty to me. At least I could see under the present program a \$30 or \$40 billion in addition to the \$56 billion that was part in August.

It is really a question of whether people would be willing to consider taking on income relating the Medicare program in general, not making it a welfare program, but income relating the Medicare program. I think that would again allow you to have considerably more funding for the part that I worry about most, the lowest income of the population.

Mr. WAXMAN. Would you have an employer mandate to cover the working people?

Ms. WILENSKY. I prefer the individual mandate. But I agree, if you don't have a mandate, you are not going to get everybody covered. My concern is that when you have an employer mandate, you end up doing what we see being done now with the subsidy for small firms with low-income workers, which then leads to distortions as firms try to reconfigure themselves so as to take best advantage of the subsidies that are offered.

Alan Krueger from Princeton University, who is the researcher who came out with the recent estimate that minimum wages don't increase job loss as much as some had feared when he looked at the McDonald's experience in New Jersey, estimated that the kinds of distortions associated with the subsidy to low-income plans—firms such as included in the Health Security Act, could cost a million jobs.

That is the kind of concern that I have about working through employer mandates. So I much prefer a March targeted approach to individuals.

Mr. WAXMAN. Thank you.

Mr. Bliley?

Mr. BLILEY. Thank you, Mr. Chairman. Mr. Abramowitz, if the Clinton plan is enacted, where would you advise your clients to invest their money?

Mr. ABRAMOWITZ. Well, health care is 15 or 14 percent of the GDP. There is the other 86. That would be a pretty good place to look. There are also other countries. But in effect, the Health Security Act says, don't invest in health care. We want to live off of historical capital. Don't put any new capital—any new capital, we are going to price control and we are not even going to tell you what the rate of return is. All we know is we don't even know if there is going to be a rate of return. People will put their money in other things.

The same problem is with the physicians. When I was at Columbia, the smartest kids in my class were premedicines. If you were the smartest kid in your class and you were 20 years old, and you were trying to decide, should I go to graduate school, should I go to business school, they don't regulate you there, should I go to law school, they don't regulate you there, or should I go to medical school?

If I go to medical school, I have to work for 5 to 10 years, I have to absorb \$100,000 of debt, and then the government is going to price control me like a civil servant. Forget it. I will go to business school or law school.

If this plan goes through, we are going to have a shortage of high quality American doctors. We are going to have to import high quality foreign medical graduates to make up for the fact that our best and brightest aren't going to go into the medical field. You can't socialize 15 percent of the economy and not socialize the other 85 and expect resources to go to the 15.

Mr. BLILEY. Dr. Rivlin makes the statement, health reform is absolutely essential to further deficit reduction. Do you agree with this, and could you also comment on the administration's assertion that the Clinton plan will lead to \$58 billion in deficit reduction?

Ms. WILENSKY. The second part is easier. Let me start there. I think the notion that you can take on change for what is almost one-seventh of the economy, that you can make major new benefits in Medicare and early retirees, that you can bring in all the uninsured, unemployed, and move up workers who now don't have the best of the Fortune 500 insurance and reduce the deficit is just fantasy.

We have a harder time predicting what it is going to cost when we make marginal changes. And some of our experiences in Medicare, our experience with trying to project expenditures in the 1990 budget act just reinforces how difficult. So the notion that we will have deficit reduction because there is a \$45 billion cushion just belies all the experience of the last 20 years.

You do not need to have health care reform to cure the deficit any more than you need health care reform to make us internationally competitive. You ought to have health care reform because we

have too many people without insurance and because the rate of spending doesn't make any sense.

The other issues can be handled on their own if people request them. There is the issue that Medicare has been a contributor—and Medicaid has certainly been a contributor of both of those—could be dealt with directly if that was the desire. I wouldn't use that as your rationale for health care reform.

There are plenty of good rationales for health care reform on their own. You just have to make sure the fix is not causing a problem that is even worse than the disease, and the disease is bad enough.

Mr. BLILEY. Mr. Abramowitz, would you agree or care to comment on that?

Mr. ABRAMOWITZ. Sure. I would generally agree. I think that Medicare and Medicaid can do lots of things to control their own health care spending without this larger health care reform. For example, the private sector is now 25 percent HMO's. Medicaid is only about 12. And Medicare is only about 8 percent. I think the government should work on trying to increase the percentage of Medicaid and Medicare folks in HMO's.

Medicaid is a little easier because it is just easier to move Medicaid folks around politically. And so I would have mandatory Medicare HMO's over the next 5 or 10 years. The HMO's are not ready for that. You have to make sure it is done in a quality fashion. You can't just throw 30 million people into the HMO system. But I think over 5 or 10 years the HMO's could gear up to handle those folks. Instead of giving the drug benefit to Medicare beneficiaries, only give it to those who join HMO's.

I think the government could do that for free because the HMO's could manage the benefit and then kill two birds with one stone. Give Medicare drug benefits to those who want it and incentivize people to join HMO's.

Mr. BLILEY. Thank you very much.

Thank you, Mr. Chairman.

Mr. WAXMAN. Mr. Wyden.

Mr. WYDEN. Thank you, Mr. Chairman. I would like to note and then ask a question of the witnesses that before the end of western civilization is predicted under the Clinton health plan, that medical school enrollments are back up significantly, salaries of primary care providers are shooting up as well, and I think it is just important to note all of those kinds of trends as we have this discussion.

Dr. McArdle, if I might, we have got this sort of battle of the charts at this point. Everybody is weighing in with one chart or another. And we have even got a significant disparity in premium costs over on the easel over there. The right-hand column is essentially the administration's estimated premium costs. Then you have got everybody else's calculus of the premium cause, HIA, everybody else's of course significantly higher.

What can you tell the subcommittee about the populations covered by the two surveys on the easel, and exactly how they differ from the national sample used by the administration?

Mr. MCARDLE. Mr. Wyden, actually we didn't compile those numbers. We did give our own estimates which are comparable to

those, they are about 30 percent higher. We can tell but our own database.

Mr. WYDEN. Why don't you do that. What I am driving at is, I am one who feels there has not been enough hard-headed analysis of what we are seeing with the administration's numbers in the private sector. But I have the same sort of reservations about the numbers that you all are throwing around as well. And so I think it would be helpful to try to have you all tell us how you get to your numbers up there.

Mr. YAMAMOTO. I think we are really trying to strive for the very same answer, and that is what is the Health Security Act's program going to cost on average for the whole population. We are starting from different perspectives and we feel more comfortable with the data source we have available.

We are starting out with a claimant's database that consists of what we feel is a significant portion of the population, and fairly representative of what the Nation as a whole might cost if they were put under one insured program.

Every type of studies that I have seen done by academics and other consultants tends to drive me to the point that what we see as far as health care utilization for a large corporation that has employees scattered all over the United States is not that much different than the national population as a whole.

Mr. WYDEN. I would take exception with you, and let me use a specific example. The BACE plan showed on the chart is available essentially to congressional employees who are located in the Washington area. I note from your testimony that the mid-Atlantic region has much more traditional indemnity plan use, much less HMO use, much lower deductibles.

It seems health spending in the region market covered by BACE, the one we are looking at in this chart, is not very comparable to the administration's national average. And I will also tell you that what you are using is not at all close to what we have in the Pacific Northwest.

So I have to tell you, I have got some reservations about the kind of model that I see up there, and I would be interested in your analysis.

Mr. YAMAMOTO. I can really appreciate that. I lived in Seattle for 15 years of my life. In fact, I grew up in Spokane, Wash. One of the things we have done with your modeling and something that you would notice with the table that is on page 12 of our written testimony is there are a lot of different geographic differences in cost and health care utilization that we tried to take into account in our modeling. If you would note the table on page 12, the differences between the high cost sharing plan and the low cost sharing plan are radically different by geographic area.

So that is something that has to be taken into account when looking at the overall national averages, is how does everybody in all these different disparate groups, really come together to form this national average. I mean, when we really get down to the nitty-gritty of the pricing of all this, it is going to be done on the local level.

And we—

Mr. WYDEN. Any way you cut it, though, the health spending in the regional market covered by BACE doesn't seem very comparable to the administration's national average.

Mr. YAMAMOTO. No, it wouldn't. And the numbers that we have presented, we have tried to take into account all the distinct risk selection types of things that come into play when you are trying to make comparisons. So we have tried to make an apples to apples comparison.

Mr. WYDEN. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Wyden.

Mr. Brown?

Mr. BROWN. Thank you, Mr. Chairman.

Mr. Abramowitz, perhaps you in your circle of friends at Columbia were motivated only by your future earning power, but I would hope that at least some of those people who choose medicine in the future when they are young people would look to something perhaps as obscure as serving their community and thinking about what they could do while making a good living that medicine can bring to people. I was just not particularly appreciative of the comment you made that way.

A question, not on that same subject, I asked an earlier panelist, Dr. Rivlin, and didn't particularly get a good answer about the shifting responsibility for retiree premiums, for premium payments from large corporations and indirectly unions that are saddled with those costs, now shifting them to the government through this health care system.

The estimates from the administration, some people are pretty critical of that they may not be all that accurate. Can any of the four of you comment on what assumptions they made, what costs, what you see the costs that the administration has underestimated?

Ms. WILENSKY. I have only some of my information that I believe is mostly from the newspapers. One of the difficulties of being out of the administration is you don't have the same flow of instant information. The problem, as I see it, with regard to the early retiree benefit is that it is an area where behavior can change in a dramatic way. And that is usually where we have had so much difficulty in accurately predicting what a program would cost.

As I understand it right now, out of the 21 million people who are between the ages of 55 and 64, there are something like 3 million people who are retired. That means an awful lot of people are not retired. Not all of those are working. Some of these are people who have not been in the labor force.

What this means is that there is a large group of people who could become retired, and therefore take advantage of this new government benefit, and that would impact the estimated cost of the program. My understanding is that the administration has increased the estimated cost of the program since first raising it in its September 22nd or the September 7th informal release, it has raised the estimated cost once or twice by trying to acknowledge there might be some changes in behavior.

It is furthermore a problem because, in 7 years' time, we will have the first of the baby boomers hit the age of 55, and therefore

you have this bulge coming through of people who will also be able to take advantage of this proposal.

What you see is not only a shifting, if that happens, of retiree benefits that had been primarily covered by the employer to the extent that it occurred, and therefore picked up by government, but you have a new population that may—who may be at the margin, deciding should I work, should I retire, who have not retired because of concern about having health care benefits not be provided until they reach their Medicare age, having one major concern taken away.

And it is the potential change in behavior as well as the fact that you have some aging industries who can look and see a potential good deal coming down the pike. They can encourage some of their older workers to take early retirement to allow them to hire younger, less expensive, frequently more sophisticated technically, workers, and to get their high-cost retirees off of their hands into the community rating alliance.

So that there is in fact a real potential shift. My understanding is the administration has put some limit on how much you can shift your employee cost within the first couple of years. But there is an awful long time after those first couple of years where changing behavior could have a big impact on the Federal deficit.

Mr. MCARDLE. We have a considerably higher estimate for the cost of the standard benefit package. One of the difficulties for the committee is: How do you reconcile these different numbers? One problem with doing that is we can tell you what our assumptions are, but the administration hasn't specified what all its assumptions have been. So they have described their methodology but we don't know, for example, what their assumptions are.

We do have some clues, though. For example, we think they are reducing their charges by about 10 or 15 percent for uncompensated care, and you all will have to judge whether you think that is a reduction that is feasible. We have used a lower number of about 6 percent, because we also see a lot of Medicare cost shifting continuing under the new program. But that is one area of difference you could hone in on.

The other is there is something unusual about how the administration got from its single price to its family price using a four-tier structure that is in the statute. You would be well-advised to try to hone in on that and see, how did they get that family number.

Mr. BROWN. Thank you, Mr. Chairman.

Mr. WAXMAN. I would like to ask another round of questions.

Mr. Abramowitz, you indicated you think there is something going on now in health care that is pulling down costs, and you indicate HMO's seem to be a significant factor in what you call a revolution. Is that primarily the basis—and you indicated in the pharmaceutical area——

Mr. ABRAMOWITZ. Management companies in the pharmaceutical area.

Mr. WAXMAN. Are those the two reasons you think health care costs are going down? If you did nothing—if we did nothing, do you think the trends would be to find that health care bills are just not going to be rising as rapidly?

Mr. ABRAMOWITZ. On Wall Street, we have an expression, the cure for high prices is high prices. In other words, just raise your prices 10 percent a year forever, and I promise you no one is going to buy whatever you are selling. Similarly, if you raise taxes 10 percent a year forever, no one is going to be buying your services anymore in Washington. It works the same way in the public sector as in the private sector.

So that is the major factor. But there is another factor. The other factor is the national debate. The national debate has scared everybody not only in health care but consumers, it has made everybody much more price sensitive and price conscious. People are using their heads for the first time.

Whether it is using their heads to decide to buy a generic versus a brand name drug or using their heads in terms of trying to decide the lower cost plan like an HMO or PPO versus a traditional insurance company. So the point is that the mechanisms were getting set up. In other words, the HMO's and the pharmacy benefit management companies, they were doing their squeezing of the health care system, and then when the national debate came up, it just accelerated the trends that would have taken place anyway.

Mr. WAXMAN. How is it—would you explain that under Medicare, when seniors do have a choice between an HMO and the traditional Medicare system, they are not opting for the most part to join HMO's?

Mr. ABRAMOWITZ. HMO's have one great positive and one great negative. The great positive is that they are about 20 to 40 percent more cost-effective than a traditional insurance carrier. The great negative is you have to give up freedom. It is not so easy to convince people to give up freedom. I like freedom too. It is not so easy for me. I am not saying this is an easy task.

We are in effect asking people to balance how much is the money worth, how much is the freedom worth. So you won't get 100 percent of people to join in an HMO in 1 second. But the Medicare beneficiaries are joining HMO's very fast, approximately 10 or 15 percent growth every year. So that 8 percent, next year it will be 9 or 10. It is not a ground swell, but 10 or 15 percent growth is pretty fast.

Mr. WAXMAN. You think we ought to do everything we can to accelerate the trend of people belonging to HMO, either mandatorily for poor people or mention incentives for elderly and others?

Mr. ABRAMOWITZ. Yes. I like carrots more than sticks. You are taking freedom away from people, and you don't want to hit them with a stick at this time.

Mr. WAXMAN. You indicated to us that the best and brightest are reevaluating whether to go into medicine. Do you think that the best and brightest will want to go into medicine if they look at just being part of an HMO without the ability for independent practice?

Mr. ABRAMOWITZ. That is a very good question. When I talk to physicians, they all tell me, I am not going to tell my son or daughter to go to medical school. So the damage is already partially done, so to speak in terms of future generations of physicians. But there is an important difference between HMO's controlling health care and the government controlling health care.

Mr. WAXMAN. What is that difference?

Mr. ABRAMOWITZ. The important difference is that in every city if we had, for example, 10 HMO's controlling health care if there is choice, in other words—

Mr. WAXMAN. What if there is no choice? What if there is one HMO around, and a doctor is going to be regulated by the people who run it and the patients are going to be regulated by the people who run it. Why do you think that is any better than the government regulating what the doctors or patients do?

Mr. ABRAMOWITZ. In that example, I don't care, one of anything managing anything. In that example, they would be virtually the same. My argument is, in the bigger cities where you might have 10 or 20 or 5 HMO's competing with each other, if someone is grossly underpaying doctors, the doctors won't join. Conversely, if some HMO is grossly denying care to people, people will vote with their feet.

Mr. WAXMAN. You think it is important that for every person, he or she have a choice if it is an HMO, that they have a fee-for-service plan or some other alternative?

Mr. ABRAMOWITZ. Oh, yes, absolutely.

Mr. WAXMAN. Including poor people?

Mr. ABRAMOWITZ. Yes. But there it is a little different. Remember, if someone is getting an entitlement from the government, the government can define what that person is getting in return. For example, take public schools. We only pay if you join a public school—

Mr. WAXMAN. You have no problems with employers telling people, you only have one HMO, and that is it?

Mr. ABRAMOWITZ. No, I don't like that concept. I would like them to say here is an HMO that you can join, and I will pay 100 percent of the cost for you to join. You don't have to join it and I will give you that amount of money and apply it towards, let's say, three other plans or five other plans, whatever. But at least I think everyone in America should have the God-given right to join a good HMO subsidized by the employer and by the government. That is what I think we should strive for. If you want something more than that that is fine. Use your own money.

Mr. WAXMAN. And for poor people, it is like saying the rich and poor can sleep under bridges equally?

Mr. ABRAMOWITZ. That is a good point. Since many of us will have the money if we want to, to join something other than an HMO, the poorer folks, that is right, will in effect be relegated to HMO's. But by making sure no HMO can service—for example, in Medicare, you can't have more than 50 percent.

By saying you can't have more than 25 percent Medicaid, for example, it will at least have a mainstream plan, we won't have a poor plan HMO that you are stuck into because you are poor, and tough luck.

Mr. WAXMAN. So the safety valve is not necessarily that they can have a choice out of it if they are poor, but at least the HMO they belong to can't be a poor people's HMO.

Mr. ABRAMOWITZ. That is exactly right. They can't have 25 percent Medicaid folks.

Mr. WAXMAN. We have gotten to someplace where we agree.

Mr. Bliley.

Mr. BLILEY. Your line of questions, Mr. Chairman, I agree with, because that is what the Clinton plan does, it drives the poor people into HMO's and they don't have any choice.

Mr. WAXMAN. We don't want that.

Mr. BLILEY. Mr. Abramowitz, if the Clinton plan is enacted, who wins and who loses?

Mr. ABRAMOWITZ. There is a very important difference between the marketplace and a place controlled by the government. If the government takes over health care, there will be only winners. We won't have winners and losers. What I like about the private sector solution is there is winners and losers. The HMO's will win, the insurance companies will lose.

Drug companies that are not innovative will lose. Those that are innovative will win. Hospitals that are inefficient will lose. I like winners and losers. It is good for the country and also for investors. You can invest in the winners and not invest in the losers.

Under the American Health Security Act, we will only have one set of losers, in other words everybody, including I think the public.

If you look at a comparable plan, for example, the first country to adopt global budgets was the Soviet Union. Seventy-five years ago, they innovated, created global budgets, set a budget for all health care spending. Seventy-five years later, the average life-span of the Russian citizen has fallen into the 60's while we are into the 70's. They are roughly 68, we are 75.

There are a lot of problems with Russian society, global budgets is just one. But the point is, it has been tried before and it failed in the Soviet Union for a variety of reasons. And what lesson did we learn from the Soviet Union?

We learned that the doctors lost, the drug companies lost, the hospitals lost, the consumers lost, and so did the Communist Party.

Mr. BLILEY. Thank you very much. Dr. Wilensky, Dr. Rivlin's testimony places considerable emphasis on the 15 percent cushion or about \$44 billion, the administration has added to their estimate to cover possible behavioral changes that are difficult to model directly.

Do you regard this cushion as conservative?

Ms. WILENSKY. It is not even close. Let me give you a couple of examples, and again, these are all things that I think if you have lived through, you will probably remember. The \$500 billion deficit reduction package, the first one in 1990 has had \$190 billion of upward technical revisions to it since it has been passed. And this is only 1993.

And in fact a component of that had to do with Medicare and Medicaid. It was estimated we would have a reduction in Medicare and Medicaid of \$40 billion. In fact, only months after it was negotiated, the projections looked like we would see net increases of \$60 billion. We would have had \$100 billion if we had not had that \$40 billion reduction. It is not that it wasn't there. It is just that accurately understanding how much big numbers can change, how much behavior can change has been very difficult.

I think the notion of thinking that \$45 billion, when you are talking about a program as large as an \$800 or \$900 billion health care budget—and we are in fact talking about major changes almost everywhere we look in health care—and thinking that is a big deal

cushion, just belies the history of the last 20 years. So conservative is not the word I would use.

Mr. BLILEY. Thank you very much.

Thank you, Mr. Chairman.

Thank you, witnesses. It was a very good panel.

Mr. WAXMAN. I do want to compliment this panel as well. I think you have been helpful in giving us material to evaluate.

That concludes our business. The committee is adjourned.

[Whereupon, at 3:20 p.m., the subcommittee was adjourned, to reconvene at the call of the Chair.]

HEALTH CARE REFORM Benefits and Coverage

WEDNESDAY, DECEMBER 8, 1993

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:48 a.m., in room 2359-A, Rayburn House Office Building, Hon. Henry A. Waxman (chairman) presiding.

Mr. WAXMAN. The meeting of the subcommittee will please come to order.

This morning the subcommittee will continue its hearings on H.R. 3600, the President's health care reform proposal. We are holding today's hearing and will be holding additional hearings tomorrow and in January in order to prepare members for a markup on the President's bill early next year.

Chairman Dingell has referred the bill to this subcommittee and to our sister Subcommittee on Commerce, Consumer Protection and Competitiveness for matters within its jurisdiction until March 4. I recognize this is an ambitious schedule, but if we are going to enact health care reform in this Congress, we need to get started.

Today's hearing will focus on the comprehensive benefit package which the President's plan proposes to guarantee to all Americans. In addition to basic hospital, physician, and diagnostic services, as well as prescription drugs, the President's bill would also guarantee coverage for preventive services and for mental health and substance abuse treatment. This package compares favorably with the benefits now offered by many employers.

I have some concerns about the design of the benefits package that I hope to discuss with our witnesses today. We need to clarify what effect the President's bill would have on mental health benefits currently available in the public and the private sectors. We will also need to consider the implications of delaying a comprehensive mental health care benefit, particularly with respect to children, until the year 2001.

Similarly, we need to understand the role that substance abuse coverage in the benefit package could play in relationship to the Nation's drug control strategy. The President has signaled his commitment to changing the direction of previous administrations by focusing resources upon expanding the availability of treatment. Yet it appears that the effect of the President's bill may be to sharply reduce current Federal funding levels for drug treatment in order to help finance health reform.

I also think we need to look at the design of the substance abuse benefit and particularly the impact that cost sharing requirements and limits on residential care will have on access to treatment by hard-core addicts.

We have a number of witnesses today, but before recognizing and calling on those witnesses, I want to have Mr. Bliley, the ranking minority member of the subcommittee, be given an opportunity for his opening statement.

Mr. BLILEY. Thank you, Mr. Chairman. I would like to join you in welcoming our witnesses today. The benefits package in the Clinton health care plan is indeed generous compared to many plans available today, and it is important to hear any concerns that have been raised about it. It is my understanding that today's hearing will focus on the mental health and substance abuse benefits, the prevention benefits, and dental and vision benefits. These are all very important issues that deserve our attention.

Equally important, however, is the controversy surrounding comments recently made by the administration's Surgeon General, Dr. Jocelyn Elders, concerning the legalization of drugs. At a recent National Press Club luncheon, Dr. Elders made the following statement, and I quote, "And I do feel that we would markedly reduce our crime rate if drugs were legalized, but I don't know all of the ramifications of this. I do feel that we need to do some studies." She then continued and stated that some countries have legalized drugs and seen a reduction in their crime rate and there has been no increase in their drug use.

These comments by the Surgeon General, the Nation's top physician, are sadly misguided and send the wrong message to our children. As the ranking member on this subcommittee and on the Committee on the District of Columbia, I am particularly disturbed that such wrong-headed opinions are being expressed at the highest levels of this administration. I am hopeful that today's first witness, Lee Brown, the director of the Office of National Drug Policy, can speak directly to the Surgeon General's ideas concerning legalization and crime.

Concerning the substance abuse and mental health benefit in the administration's health care plan, it is my understanding, that the pricing of these benefits has been very controversial, and I am hopeful that the administration witnesses can shed some light on this controversy and provide the subcommittee with some numbers and assumptions that will help us understand how much these benefits will cost and what policies are behind them.

In addition, I hope some of today's testimony will provide some detailed explanations of the policy implications of the administration's mental health and substance abuse benefits. I am particularly concerned about the trade-off policy in the mental health benefit under which patients would trade their inpatient hospital days for more frequent, intensive, nonresidential services on a two-to-one basis. The same type of trade-off policy is also mandated for substance abuse patients where patients are required to trade in available inpatient days for outpatient substance abuse and relapse prevention treatment at a four-to-one ratio. There are some serious ethical concerns associated with this policy, and I look forward to exploring these with our witnesses today.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you very much, Mr. Bliley.

Mr. Cooper.

Mr. COOPER. Thank you, Mr. Chairman. I appreciate your holding a hearing on this important topic.

I think all Congressmen and Senators, all Americans, should be committed to having comprehensive mental health benefits and substance abuse benefits as part of any basic benefits package. I think that there is going to be a lively discussion about the extent of these benefits.

I have benefited greatly from learning not only from the First Lady on a whole range of health care issues but also from Tipper Gore and her incredible leadership in health care reform and mental health benefits. I have also benefited greatly from a company, Federal Express, in Memphis, Tenn., that has been using a managed benefit for some time in an effort to avoid the arbitrary limits of 30 days inpatient, 60 days outpatient, so that the real health of the patient can be taken into account and effective treatments given.

Arbitrary limits of any type don't put the patient first, they put other things first, and I think we need to be struggling to have a system that does really put the patient first. So I still have a tremendous amount to learn in this area, and I look forward to the expert testimony of the witnesses, and I appreciate you, Mr. Chairman, calling this hearing.

Mr. WAXMAN. Thank you, Mr. Cooper.

Mr. Kreidler.

Mr. KREIDLER. Thank you, Mr. Chairman.

I, too, appreciate your holding this hearing and have some comments that I would like to enter into the record and will pass on my comments.

Mr. WAXMAN. Without objection that will be the order.

[The opening statements of Mr. Kreidler and Mr. Towns follow:]

STATEMENT OF HON. MIKE KREIDLER

Mr. Chairman, I'm glad we are having this hearing, because the benefit package is at the heart of health care reform. It is a lot easier to talk about health benefits in general than it is to define those benefits explicitly. But I think that's a challenge we should do our best to meet.

In doing so, I hope we will keep in mind three principles:

First, the benefit package should be comprehensive, not the kind of "bare bones" package some people have advocated. Guaranteeing only "basic" or "catastrophic" benefits guarantees a multi-tier system of health care, where the rich can have anything they want and the poor have no economic leverage to obtain quality care.

Second, despite some of the things we've been hearing from New Orleans, medical doctors are not the only people who know how to provide high quality health care. Health plans should use the services of nurses, physician assistants, therapists, and other qualified professionals. Equally important, they should empower those professionals to make decisions their skills and training qualify them to make.

Third, when one third of Americans use so-called "alternative" health care providers, health plans should be encouraged to offer their services. Two major plans in my State, Blue Cross of Washington and Group Health Cooperative of Puget Sound, are talking about incorporating acupuncture, naturopathy, and other non-traditional care into their benefit structures.

The benefit package spelled out in the President's Health Security Act may not be the ideal package, but I think it is consistent with those principles. However, I am concerned that the bill does not spell out how health plans are supposed to assure access to the full range of provider classes and health services available under State laws.

Finally, let me say that it's easy to talk about adding benefits, but harder to pay for them. I hope that anyone who advocates additional benefits today will also discuss how they should be financed, or how they will make limited health care dollars go farther. Cost containment is just as important a goal as comprehensive coverage, and by now we all should know we can't have one without the other.

OPENING STATEMENT OF HON. EDOLPHUS TOWNS

Today's hearing focus on health benefits, particularly as they affect coverage for mental health and substance abuse treatment, speaks directly to what the reform debate is really all about: what if we do not adequately structure the anti-trust and "safe harbor" provisions under reform, will we limit access to nonphysician providers who may be better positioned to deliver care in certain settings? Will we begin to treat mental health and substance abuse as health problems that are just as important as physical health conditions? If we insist on co-payments and deductions for these benefits, aren't we restricting access to medically necessary mental health services to only those who can afford to pay? If we are to have a reform that is positive, one which will enhance the quality of health care that is available to all Americans, then we must ensure that mental health and substance abuse treatment receive the kind of high priority that the Second Lady, Tipper Gore, established early on in the health care reform debate.

This morning, I must echo the concerns raised by my distinguished Lt. Governor, Stanley Lundine of New York, about whether the reform proposal before us will really enhance the treatment options currently available to substance abusers. His testimony this morning points out that the administration's proposal, while recognizing substance abuse as an important public health problem, may actually "reduce the quality and level of treatment available for those with the most serious and chronic addictions." For example, as someone who has promoted Medicaid reimbursement for the residential treatment of pregnant substance abusers, I am concerned that limits of 30 days for residential care would have the affect of undercutting the current clinical practice of placing pregnant women into residential treatment facilities.

On the question of mental health benefits coverage, we should be mindful that there are many people with severe mental illnesses that can not be addressed by short residential treatment stays or through outpatient care. For example, Medicaid institutions for mental diseases (IMD's) provide institutionalized care for the severely mentally disabled. The States are currently spending \$2.0 billion in Medicaid funds to care for these individuals. We need to make sure that the Medicaid "long term care services" provision continues current law and authorizes coverage for IMD's. In addition, illnesses such as clinical depression often require residential treatment longer than 30 days. And I might add here that manic depression and schizophrenia are two illnesses which demonstrate the necessity for the availability of a variety of drug therapies because patients often respond quite differently to drugs designed to treat mental illness. So I hope we will be mindful in the context of health care reform next year.

Finally, as a former drug rehabilitation clinic administrator, I must loudly protest the merger of the substance abuse treatment benefit with the mental health benefit under the Health Security Act. This limitation means patients with both health problems will have access to only one set of benefits. Nowhere else in the Act do we assume that two diseases can be treated though they were the same disease. I can tell you from personal experience that these health problems can not be addressed through the same treatment modality. As Ellen Weber from the Legal Action Center noted in recent testimony, "Addiction and mental illness are two distinct diseases that are treated by different professionals in different settings and require different therapeutic approaches". This merged benefit should be eliminated in the final health reform bill.

Health care reform has the potential to expand access and increase coverage for health conditions which have previously been ignored for all but the very wealthiest in our society. Let us not keep mental health and substance abuse treatment on the "back burner" of health care delivery. I am certain that we can design a health care delivery system which will improve rather than detract from the current treatment programs for these health problems.

Mr. WAXMAN. Our first witness this morning is Lee Brown, director of the President's Office of National Drug Control Policy. Dr. Brown is a member of the President's Cabinet and brings to this position a distinguished career in law enforcement. We have asked

Dr. Brown to help us better understand the extent to which health reform will impact the President's National Drug Control Strategy.

We welcome you to our hearing today. Your prepared statement will be made part of the record in its entirety. We would like to ask you to summarize your testimony so we will have an opportunity for questions and answers.

But I suppose while you are not here to speak about the statement by the Surgeon General yesterday, since Mr. Bliley raised it in his own opening comments, perhaps you would like to clarify for us what the administration's policy is on this matter, and then, without objection, we won't hold that on your time for the presentation today, but perhaps you can dispose of that issue and then we can get on to the purpose of the hearing.

STATEMENT OF LEE P. BROWN, DIRECTOR, OFFICE OF NATIONAL DRUG CONTROL POLICY, EXECUTIVE OFFICE OF THE PRESIDENT, ACCOMPANIED BY BERNARD S. ARONS, DIRECTOR, CENTER FOR MENTAL HEALTH SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. LEE BROWN. Certainly, Mr. Chairman.

As you may call, in September the President issued a report, an interim report, as requested by the Congress, called "Breaking the Cycle of Drug Abuse." In this report, we state very firmly the administration's position that we are unequivocally opposed to the concept of legalizing illegal drugs. We believe, as we have stated in the report, that this could lead to the destruction of our Nation as we see it today. So our position is quite clear; there is no unclarity at all about it. We feel that the drugs that are currently illegal should remain illegal, and we do not support in any way the call for legalization. We think that is surrender. We think that it will lead to even more problems in terms of cost, in terms of misery, in terms of lives that are lost, and therefore our position, as I said, is unequivocally clear that we are opposed to the legalization of illegal drugs.

Mr. WAXMAN. Thank you. Please proceed with your statement.

Mr. LEE BROWN. Mr. Chairman and members of the committee, I have with me Dr. Bernard Arons, who is the director of the Center for Mental Health Services. He will assist me in being responsive to the questions that you may have.

But I am pleased to be with you today to address and discuss the administration's commitment to substance abuse treatment. As you know, certain benefits are provided by the President's health care reform proposal. Health care reform is important to our long-term National Drug Control Strategy. Ultimately substance abuse services should be fully incorporated into our health care system, and such full incorporation is envisioned by the year 2001.

Even in its early stages of implementation, health care reform will improve access and remove certain obstacles to substance abuse treatment for most Americans. Many more substance abuse benefits will be eligible for coverage under the American Health Security Act than is presently the case.

For example, those with preexisting conditions will no longer be excluded from coverage, those who require and use treatment serv-

ices will no longer face the lifetime limits common to many policies, and support for related services that will remove barriers to treatment participation are included under companion public health initiatives, services such as transportation, outreach, patient education, and translation services.

In general, health care reform is designed to encourage community treatment in the least restrictive environment. To accomplish this, the States are provided with maximum flexibility and challenged to make full, coordinated use of all available treatment resources. Specifically, through initial day and visit limits and a benefit substitution approach, the plan intends to spur better assessment, treatment/patient matching, treatment progress monitoring, and transition planning.

In simple terms, the plan uses 30 days of inpatient coverage as the annual coverage base and allows the substitution of 1 inpatient day for 2 days of intensive outpatient treatment or 4 days or visits of outpatient treatment. In this manner, the plan attempts to avoid and contain costly hospitalization and residential care.

In addition to controlling costs, it is hoped that this approach will spur the development of skills in planning, management, and evaluation on which to base a sound approach to managed care which will be essential when benefit limits are lifted in 2001.

Of course, health care reform in its early stages of implementation cannot be expected to resolve the entire problem presented by heavy and addicted drug users, many of whom need long-term care now and many of whom are very poor. So, Mr. Chairman, to provide the appropriate context for our discussion, I would like to speak very briefly to the state of the drug problem in America as I see it.

The latest surveys indicate that about 11.4 million Americans used some illegal drugs at least once a month last year. That is down from a high of 24 million in 1979. This decline among so-called casual users has been especially sharp among young people as measured by a variety of survey instruments.

I think we all can appreciate that 11.4 million Americans using drugs is still far too many, and of course every addict starts out as an intermittent or casual user. You have probably observed that we don't hear as much about the drug problem as we once did. If we can believe public opinion polls, drugs are no longer perceived as public enemy number one. This is largely a result, at least in my view, of the progress we have made as a Nation in reducing the number of individuals who use drugs occasionally, the so-called casual or the nonaddicted user.

I believe, however, that many have been too quick to embrace this good news as a sign that the drug problem has been virtually solved when, in fact, the drug situation remains very serious and signs show it becoming even worse.

Despite the substantial and significant decline in nonaddicted drug use, we still have got two very serious problems that aren't getting better. The first is the persistence of chronic or hard-core drug use. A number of surveys as well as hospital emergency room data confirm the continued high rate of hard-core drug use, especially in our inner cities, and especially among our disadvantaged citizens.

We estimate that there are between 2 and 3 million heavy drug users. Many are addicted to cocaine, especially crack cocaine, often used in combination with other illegal drugs and alcohol. And heroin, our old nemesis of previous decades, now claims about 600,000 addicts and is showing signs of making a deadly comeback. In fact, heroin was one of the substances involved in the recent drug overdose death of the young actor River Phoenix, underscoring its availability in the west as well as the northeast.

Recent data from the Drug Abuse Warning Network, or the DAWN program, which reports on drug-related medical emergencies, showed a 10 percent nationwide increase in drug-related hospital emergency room visits between 1991 and 1992. Within that overall figure are some chilling statistics about cocaine and heroin. Cocaine-related emergency room episodes were up 18 percent over the previous year; heroin-related episodes increased even more, a dramatic 34 percent.

It has become clear that the drug epidemic that began in the late 1970's is becoming increasingly concentrated, virtually epidemic, among the Nation's heaviest users and in the Nation's poorest neighborhoods, and while infrequent use of drugs is going down, heavy use now appears to be increasing.

Chronic, hard-core use is responsible for a great deal of our violent crimes, crimes committed by users under the influence of drugs, crimes committed to finance their life-styles, and crimes committed by traffickers and dealers in fighting for territory and organizational control.

Hard-core drug use drains billions of dollars from our economy through a vast money laundering network. It drains billions more through the medical costs of the emergency room visits resulting from these crimes. It corrupts the essential institutions of our society that make civilized life possible, our families, our political system, our social services, our civic organizations. It has been estimated that up to 80 percent of the drugs on the streets are consumed by the chronic hard-core drug user.

A second major problem is with our young people, and not just those in our inner cities. The most recent survey of young peoples' attitudes and behavior with respect to illegal drugs showed that long-term decline in drug use among youth may have ended. Their use of some drugs, such as marijuana and LSD, is now actually increasing, and fewer eighth graders perceived that cocaine or crack use was harmful in 1992 than in 1991. I would submit this may be the most troubling indication of all the data that we have at our disposal.

You may have read in newspapers recently about a study of the exposure of very young children here in the District of Columbia to drugs and drug trafficking. The results were shocking. Three of every four fourth graders reported having watched an illegal drug sale. One in 10 seventh graders said they had been asked to sell drugs but refused, and 1 in 20 said they had actually agreed to sell drugs. That is the environment that we find our children operating within.

These are the problems I agreed to tackle in accepting the responsibility to direct the Office of National Drug Control Policy last June. Because I believe that policy should guide budget decisions,

I set out to work immediately to forge a policy that the President could adopt to guide our National Drug Control Strategy.

In September, the President released the administration's interim National Drug Control Strategy, entitled "Breaking the Cycle of Drug Abuse." This document states the principles that are guiding the preparation of the next detailed strategy and drug control budget due in February of 1994.

To underscore his support for this effort, the President has directed me by an Executive Order signed on November 16, 1993, to include specific initiatives and funding levels to ensure the allocation of adequate budget resources for drug control priorities.

The strategy underscores that reducing hard-core use is paramount to the successful resolution of the Nation's drug problem. This requires that we work aggressively to reduce the disparity between the number of those who seek drug treatment and the availability of treatment capacity. Unless we can increase treatment capacity, the physical and psychological debilitation often caused by substance abuse and a drug-using life-style will overwhelm our health care system with increased incidents of emergency room episodes for overdoses, hepatitis, tuberculosis, HIV/AIDS, drug-exposed infants and children, and other serious drug-related problems.

One of the basic tracks on which our strategy proceeds, that is, concentration on demand reduction efforts, is particularly relevant to our discussion today. In that context, we intend to mount an aggressive drug treatment strategy with heavy or addicted drug use as its primary target.

We intend to increase treatment capacity so that those who need treatment can receive it. We will give special focused attention to solutions of the problem of chronic heavy drug use from both the criminal justice and the public care perspectives. We will use all components of the criminal justice system to promote drug treatment using innovative programs where they have shown to be effective. We will link habilitation, social, and vocational services to drug treatment to ensure that every drug user receives the support and skills they need to prevent a relapse and recidivism.

Finally, we will focus on drug addiction as a health care problem and enact national health care legislation that sets us on course to make drug treatment part of a comprehensive health care package.

If we are going to have any lasting impact, our commitment must be constant, it must be long term, and, frankly, I anticipate in the foreseeable future some of the short-term indicators of the drug problem in America may not be positive. I also realize that we are facing a serious problem during a period when fiscal constraints place drug control priorities in competition with many other worthy social programs.

However, Mr. Chairman, I am convinced that we cannot afford to diminish our commitment. The cost of not treating those addicted to drugs and alcohol is simply too high. According to a recent study, alcohol and drug abuse cost our Nation nearly \$170 billion each year. We can't afford not to treat those who need it.

One current estimate suggests that as many as 1.1 million persons do not receive treatment because of inadequate capacity. It is certainly true that not every abuser needs long-term treatment.

For some, testing and monitoring are enough. For others, self-help groups have proven effective. But the majority of addicts and heavy users need long-term help.

Mr. WAXMAN. Dr. Brown, the rest of that statement is going to be in the record. I want to stop you because we want to get on to some questions.

Mr. LEE BROWN. Very good. Let me just conclude by saying that our objective is to make sure we have the availability of treatment services for that population that needs it with a special emphasis on the hard-core addicted drug user.

[Testimony resumes on p. 159.]

[The prepared statement of Mr. Lee Brown follows:]

OPENING STATEMENT

THE HONORABLE LEE P. BROWN

DIRECTOR

OFFICE OF NATIONAL DRUG CONTROL POLICY

Mr. Chairman, and members of the subcommittee, I am pleased to be with you today to discuss the Administration's commitment to substance abuse treatment. As you know certain benefits are provided by the President's Health Care Reform Proposal. Health care reform is important to our long-term National Drug Control Strategy. Ultimately substance abuse services should be fully incorporated into our health care system. Full incorporation is envisioned by the year 2001.

Even in its early stages of implementation, Health Care Reform will improve access, and remove certain obstacles, to substance abuse treatment for most Americans. Many more substance abuse benefits will be eligible for coverage under the American Health Security Act than is presently the case; those with "pre-existing conditions" will no longer be excluded from coverage; those who require and use treatment services will no longer face the "lifetime limits" common to many policies; and support for related services that will remove other barriers to treatment participation are included under companion public health initiatives -- for example, transportation, outreach, patient education, and translation services.

In general, health care reform is designed to encourage community treatment in the least restrictive environment. To accomplish this, the States are provided with maximum flexibility and challenged to make full, coordinated use of all available treatment resources.

Specifically, through initial day and visit limits and a benefit substitution approach, the plan intends to spur better assessment, treatment/patient matching, treatment progress monitoring, and transition planning. In simple terms, the plan uses 30 days of inpatient coverage as the annual coverage base and allows the substitution of one inpatient day for two days of intensive outpatient treatment or four days/visits of outpatient treatment. In this manner, the plan attempts to avoid and contain costly hospitalization and residential care.

In addition to controlling costs, it is hoped that this approach will spur the development of skills in planning, management, and evaluation on which to base a sound approach to managed care, which will be essential when benefit limits are lifted in 2001.

Of course, Health Care Reform, in its early stages

of implementation, cannot be expected to resolve the entire problem presented by heavy and addicted drug users, many of whom need long-term care now and many of whom are very poor.

To provide the appropriate context for our discussion, I would like to speak of the state of the drug problem in America as I see it. The latest surveys indicate that about 11.4 million Americans used some illegal drug at least once a month last year, down from a high of 24 million in 1979. This decline among so-called casual users has been especially sharp among young people, as measured by a variety of survey instruments.

Now 11.4 million Americans using drugs is still far too many. And of course every addict starts out as an intermittent or casual user. However, you've probably observed that we don't hear as much about the drug problem as we once did. If one can believe public opinion polls, drugs are no longer perceived as "Public Enemy Number One." This is largely a result, in my view, of the progress we've made as a nation in reducing the number of individuals who use drugs intermittently, the so-called "casual" or non-addicted user.

I believe, however, that many have been too quick to embrace this good news as a sign that the drug problem has been virtually solved, when in fact the drug situation remains very serious and shows signs of becoming worse.

Despite the substantial, and significant, decline in non-addicted drug use, we've still got two very serious problems that aren't getting better. The first is the persistence of chronic, or hard-core, drug use.

CHRONIC HARD CORE USE

A number of surveys, as well as hospital emergency room data, confirm the continued high rate of hard-core drug use, especially in our inner cities and among the disadvantaged. We estimate that there are between 2 and 3 million heavy drug users. Many (about 2.1 million) are addicted to cocaine, especially crack cocaine, often in combination with other illegal drugs and alcohol. And heroin, our nemesis of previous decades, now claims about 600,000 addicts and is showing signs of making a deadly comeback. In fact, heroin was one of the substances involved in the recent drug overdose death of the young actor River

Phoenix, underscoring its availability in the West as well as the Northeast.

Recent data from the Drug Abuse Warning Network -- or DAWN, which reports on drug-related medical emergencies -- showed a ten percent nationwide increase in drug-related hospital emergency room visits between 1991 and 1992. Within that overall figure are chilling statistics about cocaine and heroin. Cocaine-related emergency room episodes were up 18 percent over the previous year. Heroin-related episodes increased even more, by a dramatic 34 percent.

It has become clear that the drug epidemic that began in the late 1970s is becoming increasingly concentrated -- virtually endemic -- among the Nation's heaviest users and in the Nation's poorest neighborhoods. And while infrequent use of drugs is going down, heavy use now appears to be increasing.

Chronic, hard-core drug use is responsible for a great deal of our violent crime -- crimes committed by users under the influence of drugs, crimes committed to finance their lifestyles, and crimes committed by traffickers and dealers in fighting for territory and

organizational control. Hard-core drug use drains billions of dollars from our economy through a vast money laundering network. It drains billions more through the medical costs of the emergency room visits resulting from these crimes. It corrupts the essential institutions of our society that make civilized life possible: our families, our political system, our social services, and our civic organizations. And it has been estimated that up to 80 percent of the drugs on the street are consumed by chronic, hard-core drug users.

DRUG USE AND ATTITUDES OF YOUNG PEOPLE

The second major problem is with our young people -- and not just those in the inner cities. The most recent survey of young people's attitudes and behavior with respect to illegal drugs shows that the long-term decline in drug use among youth may have ended. Their use of some drugs -- marijuana, and hallucinogens such as LSD -- is now actually increasing. And fewer 8th graders perceived that cocaine or crack use was harmful in 1992 than in 1991. This may be the most troubling indication of all.

And you may have read in the newspapers recently

about a study of the exposure of very young children in the District of Columbia to drugs and drug trafficking. The results were shocking. Nearly three of every four fourth graders reported having watched an illegal drug sale, one in ten seventh graders said they had been asked to sell drugs but refused, and one in twenty said they had actually agreed to sell drugs.

THE INTERIM DRUG CONTROL STRATEGY

These are the problems I agreed to tackle in accepting the responsibility to direct the Office of National Drug Control Policy last July. Because I believe that policy should guide budget decisions, I set to work immediately to forge a policy that the President could adopt to guide our National Drug Control Strategy.

In September, the President released the Administration's Interim National Drug Control Strategy, titled Breaking the Cycle of Drug Abuse. This document states the principles that are guiding the preparation of the next detailed strategy and drug control budget, due in February of 1994.

To underscore his support for this effort, the

President has directed me, by an Executive Order signed on November 16, 1993, to include specific initiatives and funding levels to ensure the allocation of adequate budget resources for drug control priorities.

The strategy underscores that reducing hard-core drug use is paramount to the successful resolution of the Nation's drug problem. This requires that we work aggressively to reduce the disparity between the number of those who seek drug treatment and available treatment capacity. Unless we can increase treatment capacity, the physical and psychological debilitation often caused by substance abuse and a drug-using lifestyle will overwhelm our health care system with increased incidence of emergency room episodes for overdoses, hepatitis, tuberculosis, HIV/AIDS, drug exposed infants and children and other serious drug-related problems.

One of the basic tracks on which our Strategy proceeds -- concentrating demand reduction efforts -- is particularly relevant to our discussion today.

- o We intend to mount an aggressive drug treatment strategy, with heavy, or addicted, drug use as its

primary target. We plan to increase treatment capacity so that those who need treatment can receive it.

- o We will give special, focused attention to solutions to the problem of chronic, heavy drug use from both the criminal justice and health care perspectives.
- o We will use all components of the criminal justice system to promote drug treatment, using innovative programs where they have been shown to be effective.
- o We will link habilitation, social, and vocational services to drug treatment, to ensure that heavy drug users receive the support and skills they need to prevent relapse and recidivism.
- o And finally, we will focus on drug addiction as a health care problem and enact national health care legislation that sets us on course to make drug treatment part of a comprehensive health care package.

THE NEXT STRATEGY

MAINTAINING THE COMMITMENT TO TREAT THE HEAVY USER

If we are to have any lasting impact, our commitment must be constant and long-term. And, frankly, I anticipate in the foreseeable future some of the short-term indicators of the drug problem in America may not be positive. I also realize that we are facing a serious problem during a period when fiscal constraints place drug control priorities in competition with many other worthy social programs.

However, I am convinced that we cannot afford to diminish our commitment. The cost of not treating those addicted to drugs and alcohol is simply too high. According to a recent study, alcohol and drug abuse costs our Nation nearly \$170 billion each year. We can't afford not to treat those who need it.

TARGETING TREATMENT CAPACITY

One current estimate suggests that as many as 1.1 million persons do not receive treatment because of inadequate capacity. It is certainly true that not every abuser needs long-term treatment. For some, testing and monitoring are enough; for others self-help groups have proven effective. But the majority

of addicts and heavy users need long-term help.

As I said, budget discussions are still underway within the Administration and dollar figures are not yet available; however, I have asked my staff to review the options available to implement an interrelated set of commitments the President has made -- treatment for hard-core users, flexibility for States and localities in implementing treatment and prevention programs, and a reduction in unfunded mandates.

EXISTING CONGRESSIONAL PRIORITIES

I believe there is sufficient agreement between the Congress and the Administration to enable us to make modest but concrete progress. For example, the Congress has already established priority populations for drug treatment -- pregnant addicts, addicted mothers with children, and injecting drug users. However we simply cannot limit our efforts to these targeted groups. The problem of hard core drug use is too large and the need too great to simply fail to try and reach all serious drug users -- men and women -- who would benefit from treatment.

By maintaining public support for drug treatment, implementing these Congressional priorities, and effectively targeting additional resources in FY 95, we can begin to protect the next generation, foster community stability, and stem the criminal and infectious disease consequences of heavy drug use.

TREATMENT ON APPLICATION

In simple terms, these priorities are workable. We can assume that anyone from these priority populations who asks for drug treatment will get help. It seems reasonable to require that treatment be provided; however, if entry into formal treatment is not immediately possible, specific interim services should be provided until it is possible. At a minimum, there should be continuing contact and preparation for full treatment participation. Case management and other outpatient benefits under the Health Care Reform proposal can serve here to get addicts initiated in treatment.

FLEXIBILITY AND ACCOUNTABILITY

On another front, I think we should consider focusing less on a multitude of mandates and more on

getting services to priority populations and on treatment program outcomes. In my view as a former local official, States will willingly accept accountability for performance if we grant them the flexibility to perform creatively.

And, finally, we need to find ways to expand low-cost treatment and support service capacity. Self-help groups and community recovery centers like the ones now beginning to operate in the District of Columbia deserve our attention. It may be that for a very modest public investment, we can provide expansion of outpatient drug treatment capacity in the communities where recovering addicts live, offer a place for self-help and counseling groups to meet during the evening and early morning hours, and provide training sessions in life skills. This is another area where creative application of certain benefits under Health Care Reform can serve to empower communities and complement other treatment and collateral services.

These are a few of the ideas under consideration at ONDCP, as we develop the FY 95 budget and the February National Drug Control Strategy. I would invite your comments and suggestions and I hope you will join President Clinton and myself in a commitment to drug treatment for the hard-core populations. Thank you.

Mr. WAXMAN. Thank you very much.

That clearly has got to be our goal, to make sure that we make treatment available to all those who need it and especially those who want it. It seems to me incredible that we have people who want to get into drug treatment and then are turned away because there aren't enough slots available for them. They are told to come back in another 3 weeks or another 1 or 2 months. One could easily imagine, they are not going to be coming back at all.

In that regard, how do you see our efforts to make sure that drug treatment is available? How do you see that fitting in with this national health care reform proposal? Will we rely on the national health reform proposal to replace the Federal programs that are now targeted at the hard-core drug users, or are we looking at a supplement to those programs?

Mr. LEE BROWN. I feel that the provision within the health care reform package that calls for treatment for substance abuse as part of the national health care system has been very significant. Indeed, when approved by Congress and implemented, it will be historic. It will go a long way toward bridging that gap that now exists between those who need treatment and the ability of the country to provide such treatment. It will not answer all the problems.

Mr. WAXMAN. But do you see that we are going to have it replace existing programs when we have a national health benefit, or do you see it in addition to and supplementing existing programs?

Mr. LEE BROWN. I see it as supplementing. We will still need the funding, particularly in the block grant, to address those who are not served by the health care reform proposal. In fact, my staff is now working in addressing a budget request to assist in achieving that objective for fiscal year 1995. So as I see it, we need to continue the block grant program to meet the needs of those who are not served initially under the health care reform package.

Mr. WAXMAN. We have a billion dollars we are spending on the SAMSA block grant. It is the largest of Federal programs in this area for dealing with drug abuse. Are you aware whether or not the Department of Health and Human Services is contemplating a reduction in funding for the substance abuse block grant as a partial offset to health reform? Isn't it true that such reductions would hinder the President's ability to make treatment available to the 1.1 million hard-core addicts identified by your strategy as not receiving treatment because of inadequate treatment capacity?

Mr. LEE BROWN. I do know that early in the process of developing the health care reform package there were discussions about offsets. They were considered early in the process. I also know that those estimates are currently being reexamined, and once the figures or final decisions are made, we will be delighted to share that with you.

I think what is important, however, is that under the President's drug strategy, the issue, from our perspective, is whether we have the resources necessary to carry out the top priority of the strategy, and that is to make sure that we have adequate funds and programs available to treat those who need treatment, a combination of what is available under the health care reform package as well as the continuation of the block grant to provide those services.

Mr. WAXMAN. We obviously don't want to reduce the block grant in expectation that people will be taken care of otherwise and then find that they fall through the huge crack that we have created.

You have noted that substance abuse is a chronic relapsing disorder and that successful treatment programs must include provisions for rehabilitation, habilitation, supportive social services, and be buttressed by strong case management and supervision. Have you had an opportunity to review the extent to which the proposed health reform benefit meets your view of good drug policy?

Mr. LEE BROWN. I have had a chance to review it. The goal of the health care reform package is to make sure we provide the linkages between those services to ensure that the continuum is provided there. Indeed, my staff is now working with the staff of Health and Human Services to ensure that that takes place.

In addition, I have had the chance to visit some of the existing health care programs throughout the Nation, and talk to some of the people who are in the program, as well as the providers, and what I have said in my statement reflects what we must have in order to carry out our responsibility. So we are working on ensuring that that is the case when the health care reform package is implemented.

Mr. WAXMAN. One of the proposals that the administration is making for health care reform is to have deductibles on services. A central component of the plan is relying on these rigid length of stay limits and copayments for services like counseling or medical maintenance. In your view, are length of stay limits or deductibles appropriate for assuring the proper utilization of treatment services by the 1.1 million targeted by the President's strategy?

Mr. LEE BROWN. The goal of the health care reform package is not to set up any barriers but to encourage people who need treatment to get treatment. What we look at is a balance between the individual responsibilities and also the availability and access to the treatment. That is the goal we are trying to achieve. We do not want any barriers to prevent people from getting treatment that need that treatment.

Mr. WAXMAN. Thank you.

Mr. Bliley.

Mr. BLILEY. Thank you, Mr. Chairman.

Mr. Brown, two population groups—those with severe mental illness, and the unemployed, uninsured, particularly the homeless—would appear to pose the greatest potential cost for the mental health and substance abuse benefit. Can you explain for the committee what are the assumed costs and utilizations of these high-cost populations?

Mr. ARONS. As you correctly point out, there are certain populations, Mr. Bliley, that would have higher utilization of services. We don't have at the moment precise estimates about the utilization, but we do know that there would be available the kinds of services that would provide services for many of these individuals.

The Health Security Act provides a range of services that establish a continuum of care that would meet many individuals' requirements from inpatient hospitalization to alternatives to outpatient treatment.

In addition, many of the individuals of whom you speak might require medication or medical management, and those services are covered the same as all other health services, with no particular limits or increased copayments.

Mr. BLILEY. You have no idea how much it is going to cost?

Mr. ARONS. There have been estimates made, and there will be precise estimates made available to the committee.

Mr. BLILEY. When?

Mr. ARONS. I believe in the near future.

Mr. BLILEY. I ask that because on September 18, the First Lady herself came before the full committee, and I asked her some questions about assumptions, and she promised to get the information to us. That was the 28th of September. I followed up with a letter on the 22nd of October. I am still waiting.

Mr. LEE BROWN. What I will do is go back and find out when you can get it. If it is available, we will get it to you immediately. I will go back and get an answer to you immediately on the availability. If it is available, we will get it to you immediately.

Mr. BLILEY. Thank you.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you very much, Mr. Bliley.

Mr. Cooper.

Mr. COOPER. Thank you, Mr. Chairman.

I would first like to express my appreciation to Lee Brown for having come to Memphis a few weeks ago and help educate the good people of Tennessee on these important issues. We appreciate your leadership.

Mr. LEE BROWN. I enjoyed my visit there. Thank you.

Mr. COOPER. You were very kind of come.

In view of the large number of other witnesses, Mr. Chairman I think I will forego my questioning at this point.

Mr. WAXMAN. Mr. Kreidler.

Mr. KREIDLER. Thank you, Mr. Chairman.

Later this morning, Dr. Brown, Lieutenant Governor Lundine will propose that we shift \$1 billion in our drug abuse funds from interdiction to treatment. He feels, and many people agree, that the billions we spend to keep drugs out of this country have little impact compared to the value of spending more on treatment. Would you care to comment on that? And if we have to choose where we spend the next dollar, should we spend it on treatment or on the law enforcement side or somewhere else?

Mr. LEE BROWN. We have developed, and as indicated in our interim strategy, a comprehensive approach to address the drug problem in America. We will have to continue that comprehensive approach, a balanced approach.

If you look at where this policy, this strategy, will differ from previous policies, it is our intent to place a greater emphasis on the demand side of drugs, to reduce the consumption of drugs in America. That does not mean, however, that we will neglect the supply side. Law enforcement, interdiction, our international efforts are equally important, so we want to have more of a balance.

What does that mean? That means we need more resources. I don't think we should have the supply side competing with the demand side. We need the resources necessary to get the job done.

If we need more resources for treatment, that is what I am fighting for, to get the resources to provide the treatment services that are necessary.

We can't open up our borders and let the Escobars of the world just bring the drugs in, but indeed we are aware that we need to use all of our resources as cost-effectively and efficiently as possible. That is the reason the President recently issued a directive which calls for a controlled shift from interdiction in the transit zones to more emphasis in the source country.

It is kind of like, if you would, with the vast borders we have right now, we are on the borders trying to catch the bees as they come across the border. Our objective is to go to the bee hive in the source countries. If we can freeze the drug problem there, we will have greater success here in this country.

In summary, what I am suggesting is, I think we all can appreciate we need more treatment capacity and we need more resources to provide that. That does not suggest, however, we need to take away from law enforcement, because law enforcement is also important in our equation to address the drug issue in America.

Mr. KREIDLER. Perhaps a somewhat related area, some public health officials have indicated that in order to get a better handle on drug abuse we need to do a better job of identifying individuals at a much earlier age who are more likely, because of their family situation or any number of other factors, to become drug abusers, and then we need to be more involved at that point as opposed to waiting until somebody is a drug abuser and then trying to treat them or trying to change somebody who already has established the life-style patterns, perhaps in middle school or high school. Perhaps you can go into the elementary school age, early elementary school age, and work with students at that age. Do you have any thoughts along that line?

Mr. LEE BROWN. Yes, I do. We believe that prevention is the first line of defense in addressing the drug issue. In fact, we point out in our interim drug control strategy we probably should start even before kindergarten. From the preschool Head Start programs, we should be involving our children in drug education programs. But from a formal standpoint, certainly must have drug prevention programs from kindergarten all the way up to the 12th grade.

We have learned some things about our prevention efforts over a period of time, but they can't be at one point in the life of a child and expect that to carry all the way through, it must be continuous, it must be related to the age level of the children we are trying to reach. It must also be culturally relevant to the group we are trying to reach.

Prevention is extremely important, and we also have learned some from previous experience where previous efforts attempted today look at the individual as being the cause. We feel that there is much more involved in it than just the individual; the environment that one grows up in.

I have had the chance, for example, to talk to people who are former drug addicts or gang members or former gang members. If you listen very intensely to what they are saying, they point out some answers to the questions we have about how do we prevent drugs. They will point out that they did not have a stable family

life as we may have experienced, and thus they turn to the gang as a means of securing the love and security that we all need and want.

They point out that they have a sense of hopelessness in terms of employment. They are poorly educated, they dropped out of school, and so they have no ability to legitimately obtain the things that they want. That doesn't excuse them, but it does tell us what we need to do in terms of addressing the problem. Jobs become very critical.

If we look at the characteristics of those who are not involved in drugs, we find certain things that jump out at us: A stable family, a good education, jobs, or military service. Those are the issues that we must gear our prevention programs in a broader context than we have in the past and look at the environmental factors as well as the individual factors.

Mr. KREIDLER. Very good.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you Mr. Kreidler.

Mr. Brown.

Mr. SHERROD BROWN. Thank you, Mr. Chairman.

Law enforcement officials celebrated the killing of Escobar in South America, yet people question whether that will make much difference in the flow of drugs north.

Outline, so I understand a little better perhaps, Dr. Brown, how you allocate based on, differing from what we have done in the past, overall interdiction costs by resources for interdiction. You talked about the bee hive versus trying to stop it at the border. Give me some relative figures on how much society should be spending on interdiction and, within interdiction, how it should be spent, and on treatment and prevention and education, on that end more precisely.

Mr. LEE BROWN. At this point in time, we have developed what we call an interim drug control strategy. That strategy, which I have here, outlines this administration's broad principles in addressing the drug issue.

What we see in the strategy is that we will have a comprehensive approach if we just address the domestic side. That means we have to have law enforcement, prevention, education, treatment, and interdiction at our borders. Then we have an international program.

This document here is now serving as a basis for our developing a full blown strategy that we will submit to the Congress in February. It is also the basis of our developing our budget. I say that because of we have not developed a budget yet; we are in the budget developing process right now.

But to talk in more general terms, I believe very strongly we have to have an effective enforcement program. That is critical because people are suffering with the drug problem and we can't neglect to provide the necessary enforcement.

I believe we must have interdiction as well on our borders. We spend a great deal of resources on our interdiction program. Probably about 10 percent of our budget goes to interdiction and our international programs, which is not a substantially large amount

when we look at what we spend in other places, but we have to continue to do that.

As I said earlier—

Mr. SHERROD BROWN. Excuse me. Does that 10 percent include both the border and the suppliers?

Mr. LEE BROWN. Yes, sir.

Mr. SHERROD BROWN. OK.

Mr. LEE BROWN. As I said earlier, what the President has directed is that we will now move to a controlled shift from interdiction in the transit zones and going into the source countries. There, we want to be supportive of the countries, and particularly in Latin America, our neighbors to the south, in the area of enforcement, providing technical assistance there, as well as making sure that we help them deal with other issues that are important to America, such as democracy, such as alternative crops, rather than growing the cocoa leaf, growing some other crops, bananas or pineapples, as we see in some countries like Peru and Bolivia.

But you are correct, when law enforcement says that the capture of Escobar does not stop the problem. Escobar was on the run for some 16 months, and during the time that void was filled.

When I was in Columbia, and I had a chance to meet with the president there, one of the things that I got a commitment on was that when Escobar was captured, that they would use the same effort, resolve, and resources to attack the other cartels, particularly the Cali cartel that now supplies about 80 percent of the cocaine to the world.

I guess in summary, what we have to have is a comprehensive approach. That involves enforcement, yes; it involves interdiction, yes; it involves our international efforts; but we have to also understand that the biggest part of the drug problem is the addict. As long as we have people who are addicted to drugs and using drugs, we are going to continue to have the problems of crime and violence brought on by drug use.

The best way to deal with the supply of drugs is to deal with the demand for drugs. So to the extent we can stop people from using drugs initially, we can get those who are using drugs off or at least to reduce their use of drugs, then we are making progress.

I believe and have seen experienced throughout this country that indeed treatment does work. It bears great benefits for us. As I see it, we cannot afford not to have effective treatment programs because the big part of the drug problem is the addict.

Mr. SHERROD BROWN. Fourteen billion dollars spent, my understanding, over the last 10 years in interdiction. Was that much too much weighted towards border interdiction rather than going to the source in the last 10 years?

Mr. LEE BROWN. I think what we have to look at is that we learn from our efforts. In the past, we had a lot of drugs being flown over in aircraft. That is why we had a great deal of effort and resources in the transit zones.

The drug cartels are well financed organizations. They have their intelligence, and so they are flexible, and they have changed their strategy. We do not have the drugs flown over through the transit zones to the same extent that we did in the past. They are now coming over by commercial ways and maritime ways. That means

that we also have to be flexible and change our strategy. That is the reason we are going toward placing more of an emphasis within the source countries but not neglecting the interdiction efforts in the transit zones because one could expect that as the drug organizations see what we are doing, they will change their strategies too. So we are not going to abandon our borders or the transit zones.

Mr. SHERROD BROWN. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Director Brown.

Mr. Hastert.

Mr. HASTERT. Thank you, Mr. Chairman.

Mr. Brown, as you are aware, there has been an internal debate within the administration over the costs associated with mental and substance abuse benefits. Can you outline for the committee those differences of opinion regarding the cost estimates for the mental and substance abuse portion of the plan? Have those differences been resolved? And, if so, how were those differences resolved?

Mr. LEE BROWN. I don't have for you today any figures about what the administration feels will be the costs associated with either mental health or substance abuse. I will go back and provide what we do have for you. If it is not available, when it is available, I will provide it for you.

I can tell you what my goal is, what the goal of the President is. The goal is to make sure that we do have the resources to provide treatment for those who need treatment. The President has said consistently he wants to close that gap between the people who need treatment and the ability of the country to provide those services.

That is the reason that my staff is currently working with OMB in an effort to provide increased resources to increase the treatment capacity of the country to address the problem. Our emphasis will be on addressing the hard-core drug users because they are the ones that are bringing about much of the crime and the violence that we are concerned with. So my objective is to get the resources that are necessary to get the job done.

Mr. HASTERT. In the President's book on the health security issue, premiums are discussed. Different premiums are defined for two-parent families, single-parent families, couples, single persons. How did you arrive at the premiums if you didn't know what the costs were going to be?

Mr. ARONS. Mr. Hastert, I am Dr. Arons with the Center for Mental Health Services and have worked on the development of the plan.

There have been and there are additional estimates being made as to the cost of services, and those are being put together, and will be provided.

I don't think there were differences in estimates, there was a concern about how much of the services between the public and private sector for mental health, mental and addictive disorders, ought to be covered under the Health Security Act and how soon.

So the Health Security Act puts into implementation a program that would start with something that is better than existing plans today, moving towards the sort of provision of coverage that Mr.

Cooper has mentioned, the flexible benefits, that can be managed by a plan.

Mr. HASTERT. As you well know—and I came out of the State legislature where we dealt with appropriations bills—that much of the cost of mental health today is borne by the States and State institutions. Do you assume all that cost, too?

Mr. ARONS. Yes. This is focused on that which will be covered under the Health Security Act. About 29 percent of direct treatment costs—

Mr. HASTERT. Well, those people are citizens and they do have—

Mr. ARONS. Absolutely, but about 29 percent of direct treatment costs are, in fact, State and local funds, as you point out, a large proportion of the mental and addictive disorder treatment budget.

The President's Health Security Act is focusing on that which will be covered under the premium which will be collected through employers and individuals and subsidies from the Government.

Mr. HASTERT. But you are telling me, Mr. Brown, right now, that you don't have the costs.

Mr. LEE BROWN. I do not have that.

Mr. HASTERT. And those aren't available. You don't know what those costs are.

Mr. LEE BROWN. No, sir. We will find out what we do have and provide it to you. If we do not have it, I will let you know.

Mr. HASTERT. Do you know what the utilization is going to be? Do you know who is going to use these services? Do you have those numbers?

Mr. LEE BROWN. We know that there is approximately now about a 1.1 million gap between those who could use the substance abuse treatment services and the slots that are available; that we do know. The objective is to close that gap.

Mr. HASTERT. When you add those two together, do you have a handle on utilization?

Mr. LEE BROWN. Yes, I do. It is a little over 2 million. I can give you the exact figure.

Mr. HASTERT. Yes.

Mr. ARONS. While Director Brown is looking for that, on substance abuse, overall, we know that at the moment for mental and addictive disorders, about 11 percent of the population are receiving treatment from the health sector, both specialty and general health sector, for the mental or addictive disorders, so about 11 percent of the population during a year's period.

Mr. LEE BROWN. There are about 2.4 million people that we feel could benefit from the treatment, and the shortfall right now is about 1.1 million.

Mr. HASTERT. So there is only about 1.3 million people receiving benefit today?

Mr. LEE BROWN. That is correct.

Mr. HASTERT. So you are going to double the scope of that benefit. Is that correct?

Mr. LEE BROWN. Our objective is to close that gap, and what we want to have is, when someone wants and needs treatment, we want it to be there. There is a continuum on treatment. Everyone

would not need, for example, inpatient treatment. There could be neighborhood-based counseling of various types.

Mr. HASTERT. We understand that. But we don't know what that cost is going to be.

Mr. LEE BROWN. I do not know that.

Mr. HASTERT. But yet we have the premiums set.

Mr. LEE BROWN. I can't tell you the cost right now. When I find out, I will get back to you in terms of what we know.

Mr. HASTERT. Thank you very much. I appreciate it.

Mr. WAXMAN. I think we ought to get these cost figures. I think the members of this committee want to have that before us. Mr. Bliley has asked every administration witness that we have had for the cost figures, and I think he is entitled to get them.

Mr. LEE BROWN. As I indicated earlier, I will go back. What we have available, I will make sure that the committee receives it. If it is not available, I will tell you when it will be available.

Mr. WAXMAN. Let me ask you a question. The health reform proposal places limits on residential treatment and day treatment that are permitted in any calendar year. In the case of nonhospital residential treatment, the benefit limits treatment to 30 days.

How does this limit compare with the average treatment experience of Federal funded residential treatment programs? How does the limit on intensive day treatment compare with treatment available in federally-funded treatment programs?

Mr. ARONS. Yes, Mr. Chairman. Again, there are some very important changes in the Health Security Act that occur even immediately aside from the limits that you mentioned.

Mr. WAXMAN. I want to know about the limits. How do these limits compare to what we have already seen and experienced?

Mr. ARONS. Again, there are two groups of individuals, as you mentioned, those covered under present insurance plans, in which case the benefits that are provided are generally broader than those that exist in present plans.

For example, the Blue Cross/Blue Shield option that is available for Federal employees has significant limits for both inpatient and outpatient care and also a limit on lifetime treatment, only one treatment per lifetime for substance abuse.

You asked about in the public sector, and there are a broad range of programs, and it is certainly true that individuals in the public system have access to programs that have services beyond the limits that are available in the Health Security Act, and those will need to continue during the interim period before an integration of the system.

Mr. WAXMAN. So those who are hard core and federally funded plans are requiring a longer length of the stay for these day treatment programs and residential treatment programs than what is envisioned in the health reform proposal.

Mr. ARONS. Some of those are. There have been some estimates, and we are working on making those more precise. The 30 to 40 percent of individuals will, in fact, be covered under the limits in the Health Security Act, so that there will be others who will need treatment beyond the limits that are in this Health Security Act.

Mr. WAXMAN. And what will happen after the Health Security Act is in place? Will those who need these longer limits no longer have them available?

Mr. ARONS. Well, again, initially, it will be the same situation as there exists today although somewhat better because the benefits are somewhat better, but, as occurs today, individuals who come up against their limits, which are often more severe than those that occur in the Health Security Act, have to then go into either out-of-pocket payments or to the public sector when appropriate for ongoing treatment, and that will continue during the interim period as there is a transition to a more integrated system of care.

Mr. WAXMAN. In other words, we are going to continue to have a public sector drug treatment program during the interim. How about after the Health Security Act is in place?

Mr. ARONS. Well, certainly during the interim, and then after the Health Security Act there will obviously be responsibilities for the public system that will be ongoing: Services such as enabling services, transportation access, bringing people into the system, that will be continued responsibilities of the public sector; in addition, monitoring and setting the standards for care. We think all those will be continued responsibilities.

Mr. WAXMAN. And will there be a continued responsibility at the Federal or the public side to supplement those who reach the limits that would be in place under the Health Security Act and need to go beyond those limits?

Mr. ARONS. It is anticipated that there will be continued support while maintaining the principle that we not pay for services twice, so that those services covered under the Health Security Act, it would be anticipated that those would not be paid for in two different areas. But there would be continued support for those services not covered, and in particular, as Director Brown has pointed out, for the hard-core addict.

Mr. LEE BROWN. I do have some figures that may be more specific to your question.

One of the reasons that we are looking at expanding the treatment budget for fiscal year 1995 is to cover that which is not covered and will not be covered under the health care reform package.

Mr. WAXMAN. Well, the health care reform package isn't going to cover everybody for the benefit for some period of time, so you need something in the interim.

Mr. LEE BROWN. That is correct.

Mr. WAXMAN. But once it is all in place, you have limits, it seems to me, more severe than what is now available for many people who are hard-core addicts under federally-funded programs, and, in addition, there is going to have to be cost sharing by the people participating in that Federal program.

For example, let's say someone in a methadone maintenance program—are they going to be required to come up with cost sharing out of pocket? And what happens if they don't come up with that money?

Mr. ARONS. Yes, there is cost sharing that is required for individuals who are receiving medication treatment, in this case methadone.

Mr. WAXMAN. How much?

Mr. ARONS. This is estimated to be in a low-cost plan of approximately \$10 per visit; in a higher cost plan, approximately 20 percent of the fee.

Now this is intended to be partly a matter of individual responsibility, a commitment to treatment, having every individual in America pay something toward their treatment. It is also a form of control of utilization.

But we recognize the need to also encourage treatment for those who need to be encouraged to provide treatment, and this may be an area that needs some further thought as to where it is appropriate to try to have an individual copayment and, where it is appropriate, to try to encourage treatment.

Mr. WAXMAN. Do people now pay a copayment when they go in for a methadone maintenance program?

Mr. ARONS. In the public sector programs that are available, there is typically no copayment, although there are obviously requirements on the part of the individual for their treatment.

Mr. WAXMAN. Are we going to end up in a situation where those who want to be on methadone maintenance but can't afford to pay for their cost sharing are going to forego that treatment on the one hand, or have to go out and commit crimes to raise the money to help pay for their copayment? Is this where we are going to be?

Mr. ARONS. Well, Mr. Chairman, obviously we want to avoid that situation, and so I think this is an area that requires a close look to make sure that we have the appropriate balance between controlling the utilization, individual responsibility, and having open access to treatment such as methadone, and together hopefully we can take a closer look at that.

Mr. WAXMAN. I want to recognize any member who wishes to ask additional questions.

Yes, Mr. Hastert.

Mr. HASTERT. One short question on this.

Mr. WAXMAN. Sure.

Mr. HASTERT. Mr. Brown, we talked about doubling—almost doubling the number of people that you are going to bring in under the program, but we don't know the cost of that, and I understand that right now, and you are going to get us the costs when you get them available to you. But you think the utilization is going to almost double.

You know, I went through a period of time in the late seventies and early eighties as I sat in the State government, and we took a lot of people who were in State institutions and mainlined them, basically moved them back out into society. A lot of those folks today are the people that we call homeless people. They have had drug problems. They are basically people that don't have any money; that is why they are homeless; or they wish to be that way and still don't have any money.

Now, we are saying that those people are going to be coming in and be making copayments for treatment and that we are going to gather these folks back into some kind of an umbrella for treatment. Is that correct?

Mr. LEE BROWN. I am not familiar with what you are referring to, because I come from local government myself as a police officer and police official. We dealt with those people that were released

from the mental institutions that had no support services when they got there, and the proposed health care reform package does take into consideration those who cannot afford to pay for their treatment services.

I think one of the major aspects of the health care reform package is that it guarantees health care treatment for all Americans; those who cannot afford it will be subsidized.

Mr. HASTERT. So a lot of these people, again, probably a good part of that 1.3 million people additional that you bring into the system, are going to be people who can't pay, right?

Mr. LEE BROWN. We could expect that many of the people who are the hard-core drug users will not be employed.

Mr. HASTERT. Do you have a percentage? Do you know how many of those people—

Mr. LEE BROWN. We do not know enough about the hard-core drug user at this point in time. That is one of the reasons my office is undertaking a research project on the hard-core drug users. The surveys we have right now do not provide us adequate information, and that is a major priority for us at this point.

Mr. HASTERT. So the numbers and costs of that are still up in the air?

Mr. LEE BROWN. At this point, we cannot provide you with an answer to that.

Mr. HASTERT. Thank you.

Mr. WAXMAN. Thank you, Mr. Hastert.

Do any other members wish to ask additional questions?

If the members of the panel will permit, we will move on.

Dr. Brown, thank you very much for your presentation to us.

Mr. LEE BROWN. Thank you, Mr. Chairman, and members of the subcommittee.

Mr. WAXMAN. We are delighted to welcome back Dr. Judith Feder, principal deputy assistant secretary for planning and evaluation in the Department of Health and Human Services and one of the drafters of the plan that is before us.

Doctor Feder, we are pleased to welcome you back to our subcommittee hearing. The prepared statement that you have presented to us will be in the record in its entirety. We would like to ask you, if you would, to limit your presentation to around 5 minutes.

STATEMENT OF JUDITH FEDER, DEPUTY ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY BERNARD S. ARONS, DIRECTOR, CENTER FOR MENTAL HEALTH SERVICES

Ms. FEDER. Thank you, Mr. Chairman, Mr. Bliley, members of the committee. It is a pleasure to be here with you this morning.

I am accompanied by Dr. Bernie Arons whom you have already met and by Cheryl Austein, who are my colleagues at the Department of Health and Human Services.

As we talk about benefits this morning, I do not need to remind you that we continue to face alarming and costly indicators about problems in the health care of Americans. Between 1980 and 1990, the proportion of infants weighing less than 1,500 grams increased

18 percent for infants of black mothers and 6 percent for infants of white mothers. During this same period, the percent of mothers who began prenatal care in their first trimester of pregnancy was only 76 percent, with large differences across population groups. In 1990, less than half of the women over 50 had a mammogram in the previous 2 years.

Let me personalize these statistics by highlighting some real life experiences. The lives of Nola and Kent Olsen, a self-employed couple from Florence, Mont., changed dramatically after a car accident left Mrs. Olsen a quadriplegic and completely dependent on her husband. Only months before the accident, the Olsens cancelled the health insurance policy held through their contracting firm. It was too costly, and they had never used it. Ironically, the accident left the couple \$61,000 dollars in debt.

Mr. Chairman, it is critical, as you know, that the Nation address these problems. I am pleased to come before you today to talk about how the President's plan provides services and benefits that will enable all persons legally residing in the United States to stay healthy, prevent disease, and, when necessary, receive treatment for disease in its earliest stage.

The Health Security Act takes a major step toward addressing these problems by guaranteeing that all legal residents will have comprehensive health care coverage. The Act provides benefits which include a broad range of health services and which prohibit plans from excluding anyone due do preexisting conditions.

As you know, Mr. Chairman, we have specified in detail the President's plan the array of benefits that people will receive. It is the President's view that if we are to guarantee and provide people the security of coverage they seek, that these benefits must be specified as we move forward in the legislative process.

The President's plan offers a full range of services including hospital services, services of health professionals, emergency services, clinical preventive services, mental illness and substance abuse services, family planning services, and services for pregnant women, home health care, extended care, outpatient prescription drugs, outpatient rehabilitation services, vision care, including routine eye examinations, diagnosis, and treatment for defects in vision, and eyeglasses and contact lenses for children under 18, dental care for children, and health education classes.

This range of services is, as we believe appropriate, necessary to address and provide security for affordability of the kinds of services people need when they are ill, and they resemble the kinds of benefits that people who are today well insured have in their packages.

Our benefit package, however, is more extensive in an area that we believe is particularly critical and indeed is the cornerstone of our coverage, and that is preventive services. The comprehensive benefit package includes a wide array of such services without any cost sharing for individuals. They include periodic clinician visits, prenatal care, immunizations, routine screening for mammograms, and, in addition, for high-risk groups a screening on a periodic basis.

As you have heard, our plan also includes benefits for mental health and substance abuse. For the first time, all persons with

mental and substance abuse disorders and their families will have access to specialized services with no discrimination based on pre-existing conditions and no lifetime limits. The proposal gives health plans the flexibility to provide appropriate types, mix, and level of services for each individual.

The Act includes coverage for diagnosis, medication management, crisis services, and somatic treatment services comparable to that of other health services. It does not limit intensive treatment to inpatient coverage in hospitals but broadens it to residential settings and intensive nonresidential care such as partial hospitalization and intensive day treatment programs. Health plans also have the flexibility to use case management services.

The President is committed to making mental health and substance abuse services an integral part of the Nation's system of health care, and although we have limits on visits and on days in institutions at first, the benefit proposed for 2001 would eliminate the historic discrimination against mental illness and substance abuse by providing a benefit without limitations.

Every American, including those who are so poor that they currently qualify for health coverage under Medicaid will be able to receive the federally guaranteed benefit package. However, we recognize, as you do, Mr. Chairman, that some children who are covered under the current Medicaid benefits receive services that go beyond the guaranteed package. In an effort to ensure that there is no gap in service for low-income children, the plan includes a new, capped, Federal program for poor children consistent with protections they now receive under Medicaid.

We have also made a special effort to address the problems of families who have relatives with chronic health problems or severe disabilities. The new long-term care program which represents a major increase in spending for community-based long-term care will provide a range of community supports for people with severe disabilities regardless of their age or income.

This new program will be financed primarily by the Federal Government but with State contributions as an entitlement to the States funded at levels sufficient to provide services appropriate to the needs of people with severe disabilities, enabling them to remain at home or in the community.

The President recognized, again as you do, that providing everyone insurance coverage is a necessary but not a sufficient condition to ensuring everyone access to appropriate care. To help insure that those services are really there where people need them, the Health Security Act includes several additional investment proposals.

First, the Act includes two new grant programs to support school health education programs and to fund school health services. In addition, new funding will be authorized to help support public health initiatives of special importance to the health of children, including immunizations, lead poisoning screening, health education, and violence prevention.

Finally, the Health Security Act invests in primary care and enabling services such as transportation and outreach services and in the training of primary care doctors, including pediatricians, obste-

tricians, and family physicians to ensure that children and expectant mothers will not lack appropriate medical care.

Mr. Chairman, the Health Security Act was designed to guarantee all of us access to comprehensive medical care. The President has taken a bold step in spelling out that guarantee. Everyone can be assured that they will have the benefits that they need, and all of us can now have access to a revitalized health care system that prevents disease and promotes health but is also there when they or a loved one become ill.

I am happy to address any questions you might have.

[The prepared statement of Ms. Feder follows:]

STATEMENT OF
JUDITH FEDER, PH.D.
PRINCIPAL DEPUTY ASSISTANT SECRETARY
FOR PLANNING AND EVALUATION

Mr. Chairman and Members of the Committee:

I am pleased to come before you today to talk about the comprehensive benefit package under the Health Security Act. The Act represents the President's commitment to the American people for health security through a guaranteed comprehensive benefit package.

I do not need to remind you that we continue to face alarming and costly indicators about the health of Americans:

- Between 1980 and 1990, the proportion of infants weighing less than 1500 grams (those at greatest risk of death and disability) increased 18 percent for infants of black mothers and 6 percent for infants of white mothers.
- During this same period, the percent of mothers who began prenatal care in the first trimester of pregnancy was only 76 percent, with large difference among racial and ethnic groups.
- In 1990, only 43 percent of women over 50 had a mammogram in the previous two years. And in 1992, women earning under \$10,000 a year were 30 percent less likely to have had a mammogram in the last year than women earning more than \$20,000.

THE HEALTH SECURITY ACT

Mr. Chairman, we all agree that the nation must address these problems, many of which are preventable. I am pleased to come before you today to talk about how the President's plan provides services and benefits that will enable all Americans to stay healthy, prevent disease, and, when necessary, to seek treatment for diseases in their earliest stages.

The Health Security Act takes a major step towards addressing these problems by guaranteeing that all Americans will have comprehensive health care coverage. The Act provides a benefits package which includes a broad range of health services and which prohibits plans from excluding anyone due to pre-existing conditions. In addition, it is important to note that consumer out-of-pocket costs for health services in the comprehensive benefit package are limited to ensure financial protection, and standardized to ensure simplicity in choosing among health plans. There are no life-time limits on any benefit.

WIDE RANGE OF BENEFITS

The Health Security Act guarantees coverage for a full range of services including hospital services; services of health professionals; emergency services; clinical preventive services; mental illness and substance abuse services; family planning services (including prescribed contraceptives) and pregnancy related services; hospice care; home health care; extended care; outpatient laboratory services; outpatient prescription drugs; outpatient rehabilitation services; durable medical equipment; vision care including routine eye examinations, and eyeglasses and contact lenses for children under age 18; dental care; and health education classes. Some of these comprehensive services - such as dental care for adults and full coverage for mental health and substance abuse treatment - will be phased in over several years.

CLINICAL PREVENTIVE SERVICES

Prevention is the cornerstone of the Health Security Act. The comprehensive benefits package includes a wide array of preventive services not covered by the majority of today's insurance plans - immunizations, well-child care, mammography, pap smears and other screenings and early detection measures -

which will prevent health problems or help resolve them before they become serious illnesses.

- The plan offers periodic clinician visits - for children, adolescents, and adults - which provide occasions for preventive monitoring and counseling appropriate to each person's age, gender and developmental circumstances. These preventive services will be fully covered with no cost sharing and no deductible.
- Our first investment in healthy children is good **prenatal care for mothers**. To remove any financial barriers to these critical services, the Health Security Act provides for complete prenatal care with no cost-sharing. This includes any associated tests which are medically necessary, for example ultrasound examination.
- Children will receive a full range of prevention services, including immunizations, well-baby checkups with no cost sharing to ensure that all children get off to a healthy start.
- For women, the Act will cover a schedule of preventive screenings, tests and checkups with no cost-sharing.
- All women receive clinician visits, including clinical breast exams, at regular intervals with no cost-sharing. All women will also receive routine screening mammograms every two years, beginning at age 50, with no cost sharing.
- Additionally, women of any age can receive clinical services, including clinical breast exams, and

mammograms at any time when they are medically necessary of appropriate with cost sharing as specified by their plan.

MENTAL ILLNESS AND SUBSTANCE ABUSE SERVICES

For the first time, all persons with mental and substance abuse disorders, and their families, will have access to specialized services. The proposal gives health plans the flexibility to provide appropriate types, mix, and level of services for each individual.

The substance abuse and mental illness benefits will provide important services for Americans with these disorders. The Health Security Act represents a meaningful improvement over today's typical insurance policy that covers only a narrow range of services, and that encourages expensive inpatient care over more cost-effective alternatives.

The beginning benefit covers services that are important both to reforming the system and to caring for Americans with mental or substance abuse disorders. Distinctly different from typical insurance policies of today, the Act does not limit intensive treatment to inpatient coverage in hospitals but broadens it to residential settings and intensive nonresidential care, such as partial hospitalization and intensive day treatment programs. Also important in this mix is that the Act includes coverage for diagnosis, medication management, crisis services, and somatic treatment services comparable to that of other health services. Health plans will also have the flexibility to use case management services.

The beginning benefit adopts a flexible benefit design. Under the Act's flexible benefit structure health plans are encouraged to move to a managed benefit. Benefits such as intensive

nonresidential services (e.g., partial hospitalization and intensive day programs), outpatient psychotherapy, and substance abuse counseling are available as substitution for the more expensive inpatient and residential settings. This new structuring is consistent with the intent of the Administration's 2001 mental health and substance abuse benefit which will rely on health plan management of the benefit rather than specific limits.

The President is committed to making mental health and substance abuse services an integral part of a national system of health care. The benefit proposed for 2001 is a dramatic step toward **eliminating the historic discrimination against mental illness and substance abuse.**

PROTECTING LOW-INCOME CHILDREN

Under the Health Security Act, low-income families will be members of the same health plans with the same health card as other families in their area, and health plans will receive the same premium payment regardless of the income status of the family. People who today receive health care through Medicaid will join the alliance and receive assistance in paying premiums so that their insurance is affordable. Eligible low-income families will also receive assistance with cost-sharing.

Every American, including those who are so poor that they currently qualify for health coverage under Medicaid, will be able to receive the federally guaranteed benefit package. However, we recognize that some children who are covered under Medicaid currently receive some services that go beyond the new array of benefits. In an effort to ensure that there is no gap in service for low-income children, the plan includes a new, capped, federal program for poor children with special needs.

We are contemplating that this "wrap around" program will reflect current Medicaid criteria and will cover a federally determined set of services for eligible children under age 19. Basically, the services will include Medicaid services that are not included in the comprehensive benefit package, such as hearing aids, transportation, and some therapies.

PROTECTING INDIVIDUALS WITH DISABILITIES

Comprehensive coverage of preventive care and medical treatment goes a long way toward easing the threat of disease that faces all children and families in America. But families who have relatives with chronic health problems or severe disabilities face special challenges.

Outlawing pre-existing condition exclusions will help these families enormously. But many of them need more -- they need long-term supports to help them keep their loved-ones at home, in the family, in the community. Families are not looking to be replaced by a service system -- but they need some reinforcement. They need a real choice beyond institutionalizing their relative or bankrupting the whole family to keep their children at home. The plan offers real hope, in the form of a major new program for community-based long-term care.

The new long-term care program, which represents a major increase in spending for community-based long-term care, will provide a range of community supports to people with severe disabilities, regardless of their age or income. This new program will be financed jointly by states and the federal government. However, it will differ from Medicaid in that federal match rates will be higher but federal funding is capped, you will not have to be poor to qualify, and the program will be highly flexible. In addition the new long-term care program, though not an

individual entitlement, will be funded at a level sufficient to serve the estimated eligible population.

In addition, the Medicaid long-term care program will continue for low income children both institutional services, including ICFs/MR; and community-based services, including personal care, home health, and Medicaid home and community-based waivers.

OTHER INVESTMENTS

The President recognizes that insurance alone can not meet the needs of all Americans. To help improve access to appropriate care and to help prevent disease and promote health, the Health Security Act includes several new investment proposals.

First, the Act includes two new grant programs to support school health education programs and to fund school health services. Under the Act, \$50 million in FY 1995 will be authorized to support the planning and implementation of comprehensive school health education programs for children in kindergarten through grade 12.

In addition, the Act authorizes \$100 million in FY 1996 rising to \$400 million per year by 1999, to help fund school health services including preventive health services, mental health and social service counseling, substance abuse counseling, care coordination and outreach, management of simple illness and injuries and referral and follow-up for more serious conditions. These funds will be targeted to adolescents and communities most in need of support.

In addition, new funding will be authorized to help support public health initiatives of special importance to the health of children including immunizations, lead poisoning screenings, health education and violence prevention.

Finally, the Health Security Act invests in primary care and enabling services such as transportation and outreach services and in the training of primary care doctors including pediatricians, obstetricians and family physicians to ensure that children and expectant mothers will not lack appropriate medical care.

CONCLUSION

Mr. Chairman, the Health Security Act was designed to guarantee all persons legally residing in the United States access to comprehensive medical care. The President has taken a bold step in spelling out that guarantee. Every legal resident can be assured that they have the benefits that they need. All legal residents can now have access to a revitalized health care system that prevents disease and promotes health, but is also there when they or a loved one becomes ill.

Mr. WAXMAN. Thank you very much, Dr. Feder.

I assume that the main reason for delaying until 2001 implementation of a full mental health, substance abuse benefit is cost. What costs are attributed to the substance abuse portion of this combined mental health/substance abuse benefit, and how would such costs be impacted if the substance abuse portion were fully implemented with the main benefit package?

Ms. FEDER. Mr. Chairman, to address your first statement, there are several reasons for delaying the implementation of a mental health benefit/substance abuse benefit without limits. One has to do with our capacity to provide those services in an integrated fashion that ensures both efficiency and quality.

Congressman Cooper talked about integrated health care plans. We need to encourage their delivery and their development, in order to assure appropriate cost effective treatment, and that will take some time. We must also work toward integrating, as was discussed earlier, the public spending for these services with insurance systems.

Mr. WAXMAN. But I assume that cost is a factor and is reason why you didn't try to integrate these services immediately and get them available.

Ms. FEDER. Appropriate payment for quality services is an issue, and we need some work on it.

Mr. WAXMAN. What are the costs attributed to the substance abuse portion of this combined mental health/substance abuse benefit?

Ms. FEDER. Are you concerned about when they are fully integrated or at the current time?

Mr. WAXMAN. Well, let's talk about when fully integrated. Let's talk about both.

Ms. FEDER. OK, I will do them one at a time.

Our estimates with respect to beyond 2001 require calculations that relate to changes in the delivery system, and we are continuing to work on those.

In terms of the current benefit, the estimates that have been publicly reported assume an expenditure of approximately \$241 per person, which requires some adjustment to include in the premium, depending upon the kind of premium, family or individual, and I can provide for you the breakdown on substance abuse and mental health for the record.

Mr. WAXMAN. I would also like to get a breakdown if we wanted to implement that portion of the benefit immediately how much it would cost, and perhaps you can give that to us for the record.

I understand the plan requires copayments for outpatient services that comprises mental health/substance abuse benefits. Now one of the purposes of a copayment is to discourage unnecessary or inappropriate utilization of mental health services. What evidence exists that substance abuse treatment services for so-called hardcore addicts are overutilized? Wouldn't you agree that the problem in treating this special group is one of retention in treatment rather than overutilization of treatment, and isn't there a relationship between retention in treatment and long-term recovery?

Ms. FEDER. Mr. Chairman, as I believe Dr. Arons addressed in your previous panel, we are concerned that people get appropriate

treatment, and, as he indicated, in the design of our package we are seeking a balance between individual responsibility and appropriate access to care, and we look forward to continuing to work with you on the best arrangements to achieve that.

Mr. WAXMAN. So the arrangements you have may not be the best, and you are willing to look further at changes.

Ms. FEDER. I believe that we have established an initial balance, but if you have concerns, we are happy to respond to them.

Mr. WAXMAN. I am concerned about whether the proposed mental health benefit will meet the need of individuals with the most critical needs. Can you describe for us how an individual who is homeless and has severe mental illness would receive the comprehensive services they would need after exhausting one or more parts of the benefit, and should we conclude that at least during the transition period the mental health benefit is not intended to address the needs of those with the most serious forms of mental illness?

Ms. FEDER. Dr. Arons?

Mr. ARONS. It is estimated that perhaps approximately a third of individuals who are homeless may be struggling with a mental illness that affects and contributes to their homelessness.

It is, first of all, important that the Health Security Act does provide a good deal of services that will be relevant to those individuals and that in many cases even when an outreach worker or worker with the homeless brings someone in for treatment, they are unable to get that treatment because of lack of coverage.

So things like short-term hospitalization and alternatives to hospitalization, nonresidential intensive alternatives, medication management, will all be covered. I would estimate that a good number of individuals will, in fact, be covered within the limits of the benefit.

Those who require more intensive service services will, in fact, need the support of a public system that will need to be maintained during the interim period. That is absolutely correct.

Mr. WAXMAN. Thank you.

Mr. Bliley.

Mr. BLILEY. Ms. Feder, I am perplexed. You have outlined in detail here the benefits. Mr. Brown said in response to a question from Mr. Hastert that you are going to, for practical purposes, double the number of people getting drug abuse treatment as are currently getting, and yet no one has come up with the cost of this, but at the same time you have spelled out what the premium is going to be.

Now how can you set the premium at 7.9 percent and be certain you are going to have enough money when you don't know what the costs are going to be?

Ms. FEDER. Well, I would understand that you were perplexed if we were as ignorant as that implied. Although there is always some uncertainty about the use and cost of services, as we have testified before, we have undertaken an extensive effort in estimating costs for those people who are newly insured as well as those who are currently insured for any changes in the benefit package, and they do take into account the expected use of services for difficult, vulnerable populations.

I know you are frustrated by the fact that we have not put the detailed estimates before you, and I would like to reiterate the earlier statement that Dr. Brown made that we will respond to you as quickly as we can. It is my hope and belief that the release of this information is imminent, and while it probably will not answer all your questions, we expect to continue working with all of you to provide you that information.

Mr. BLILEY. Imminent: Is that days? Months? Weeks? You know, I mean we have been dancing this dance in September, and we are still waiting to find out what the tune is.

Ms. FEDER. Which is why I said imminent. I believe it is a matter of days.

Mr. BLILEY. Well, can you estimate what the cost of providing mental health and substance abuse coverage to the currently uninsured population is?

Ms. FEDER. What I gave you was—actually, the \$241 per capita figure is for all populations. It is across the full insured population, so it does not distinguish the currently uninsured, but those information were included in our estimates.

Mr. BLILEY. So you would say 2 million times \$240?

Ms. FEDER. No, I wouldn't want you to do that. What I would want to do is make the calculation appropriate to that population, and that is what we would have to provide you.

Mr. BLILEY. Have you got the cost of dental coverage, what that is going to be?

Ms. FEDER. I can provide you for the record the breakdowns on the specifics, but in calculating the premium, we have taken into account or carefully estimated the costs of each of the benefits, and, as I said, we will have that information for you shortly.

Mr. BLILEY. Vision, the same thing?

Ms. FEDER. On each benefit, it is the same.

Mr. BLILEY. Thank you, Mr. Chairman. I have no further questions.

Mr. WAXMAN. Thank you, Mr. Bliley.

Mr. Cooper.

Mr. COOPER. Thank you, Mr. Chairman.

Dr. Feder, I hope you can tell, the committee is somewhat frustrated on these issues. I think it has been reflected in the chairman's line of questioning and others because you see a figure with apparent precision like \$241, and yet there is no backup, and there has been no backup for months, and we want to give the administration the benefit of the doubt, but there have been apparently two well publicized cutbacks in the nature and extent of mental health benefits since the proposal was first unveiled in broad outline before Congress back in September. We need to understand the reasoning for that. I am sure there is good reason.

But it does trouble me when I see a Tennessee company like Federal Express, that doesn't have these arbitrary limits, that is currently providing today, and has for several years now, great mental health benefits apparently at lower cost with 91 percent patient satisfaction, with no arbitrary limits.

I wonder why we are talking about the year 2001. If Honeywell can do it, if DEC can do it, these other companies in the real marketplace today in 1993 can be doing this, it makes me wonder.

Ms. FEDER. I think that is an entirely legitimate question, and, as you would imagine, in the course of our process we looked carefully at the evidence that now exists on the delivery of these services, and there are a number of examples of companies that are doing it quite effectively and efficiently.

As we approached the estimating of our premium, we were conservative, as we think we ought to be, and the concern was that these experiences, though important and significant, were not universal, and that was the concern about using them as the basis for the national premium.

It is, however, the very experience that you are describing that is the basis for our belief that we can do this for the Nation in the year 2001.

Mr. COOPER. I hate to bring up this touchy subject, but there has been a great deal of discuss of universal coverage, and I understand the President's timetable is 1998. I can't help but wonder that if you need more than 30 days of inpatient mental health care, that perhaps you are not being really promised universal coverage until the year 2001 if that is the date on which these arbitrary limits may be lifted.

So it seems like there are a goodly number of our people who may not be getting the real promise of comprehensive health care until about the year 2001 when we can hope that other individuals can have the same experience that Federal Express, Honeywell, DEC, and these other companies are having today.

Ms. FEDER. I would disagree with you.

Mr. COOPER. I thought you would.

Ms. FEDER. I think that although there are a couple of areas where the benefits are somewhat limited, this population is one—the population in need of these services is likely to be among the primary beneficiaries of the guarantee that everybody, regardless of their health status, will be covered for a broad package in which most of the benefits are without limitation. That is a substantial difference from today and is universal coverage.

Mr. COOPER. I thought Chairman Waxman was quite effective in his earlier line of questioning though, talking about how this could amount to cutbacks from certain public programs today. It may be superior to some private sector plans today, but it may be inferior to the Medicaid and other programs that are out there in today's public sector.

Ms. FEDER. Our approach, when the chairman indicated earlier with respect to changes in funding for existing programs, is, as Dr. Arons indicated, a desire not to pay twice for the same services, and it is for that reason that we have taken some offsetting reductions in public programs where those services will be paid for by the insurance benefits.

Mr. COOPER. I couldn't help but notice on page 6 of your testimony that certain benefits for folks with disabilities will be provided regardless of age or income.

Ms. FEDER. That is correct. It is a home and community-based service program which is a capped program; it is not an individual entitlement, it is entitlement to the States.

Mr. COOPER. So Ross Perot, if he were disabled, would qualify for one of these benefits?

Ms. FEDER. We would certainly not discriminate. With appropriate cost-sharing, everyone is eligible, and in designing this program, Congressman, our concern has been to match a concern for, or accompany a concern for fiscal responsibility with a desire to have a strong and secure program.

It is our experience that when that program is available to all people without regard to income, it tends to be a better program and better operated, but again with appropriate cost-sharing for services.

Mr. WAXMAN. Thank you, Mr. Cooper.

Mr. Kreidler.

Mr. KREIDLER. Thank you, Mr. Chairman.

Dr. Feder, the original draft of the President's proposal includes a statement that each plan is expected to provide a sufficient mix of providers and specialties to provide adequate access to professional services. Nonphysician provider groups welcomed that statement, but they cannot find anything like that in the language of H.R. 3600. Can you explain that?

Ms. FEDER. It is our commitment, Mr. Kreidler, to eliminate barriers that have been in the way of a number of health professionals from serving in plans, and we have taken steps to include provisions for that in our legislative language. But we have not required plans to select specific providers.

It is our belief that by changing the marketplace and holding health plans accountable for delivering services efficiently, that it will be in their interest to put together the best mix of providers who can deliver quality services efficiently. If we eliminate barriers, we create opportunities.

Mr. KREIDLER. Would the administration have a problem with language specifically requiring all plans to include the services of all classes of providers authorized to practice under State law?

Ms. FEDER. It is our belief that when plans are putting together their networks, that in order to operate most efficiently, that they need flexibility to achieve that goal, and it is that flexibility that we have preserved, and that is the approach that we have taken.

There is, however, in every alliance, and in every community therefore, a plan that is an open fee for service plan that is included not only to insure that kind of plan for individuals but also to include access to that plan for all providers, so we have been concerned about the providers and that is the way we have addressed it.

Mr. KREIDLER. OK.

You are probably aware that the chiropractic profession isn't real excited right now. Does the benefit package include spinal manipulation services that chiropractors provide? Those services are not mentioned specifically in the bill.

Ms. FEDER. It includes services that would be covered if they were provided by a physician, which does include many of the services, though perhaps not all, that chiropractors provide, so we would expect absolutely that they are included subject to State licensure as qualified providers under the Health Security Act.

Mr. KREIDLER. So presuming that a physician, because of their broad licensure, could provide spinal manipulative services, presumably under State law, which I would assume would be the case

because of the broad licensure that they possess, that may meet the requirement that that service is then available.

Ms. FEDER. I would want to check on the specific, but the broad outlines that I have indicated are correct.

Mr. KREIDLER. Very good. Thank you very much.

Mr. WAXMAN. Thank you, Mr. Kreidler.

Mr. Brown.

Mr. SHERROD BROWN. Thank you, Mr. Chairman.

I hear concern in my district and around about the copayment for mental health benefits being generally higher than copays in other parts of the plan. Outline the various copays for services, if you could, in the mental health field specifically.

Mr. ARONS. Mr. Brown, I think the provision that you are referring to is the increased copayment for outpatient psychotherapy, which is at 50 percent of a fee or \$25 in the low cost-sharing plan rather than the usual 20 percent and \$10.

Mr. SHERROD BROWN. That kicks in after a number of sessions, or how does that work?

Mr. ARONS. No, that is even at the beginning. There is a limit of 30 sessions. There is a limit of 30 sessions for outpatient psychotherapy in the benefit package, and the 50 percent copayment is there from the beginning.

The rationale for that is based on a notion—it is basically again this balance of what is needed for utilization control, involvement of the individual, the individual responsibility in accessing treatment, and it was believed that for psychotherapy there was necessity for an increased copayment on the part of the individual as one of the ways in which utilization can help be controlled. So it is a discouragement. Basically it makes an individual think, and it is an involvement of that individual for that service.

Mr. SHERROD BROWN. Doesn't that put off limits pretty much that kind of therapy for families of moderate means? If it is a 50 percent copayment, doesn't that put the Government in the position of saying, "We don't think this is very important," and put the family of moderate means in a position of, "We can't afford this so we will forego the treatment"?

Mr. ARONS. Whenever there is the fixed copayment, clearly individuals at different levels of income, it will have more or less of an impact on what they can afford. For poor people, for individuals who are AFDC and SSI recipients, they would not pay the full copayment, and then in addition there is a low cost-sharing plan where the fee would be approximately \$25 per visit, which we feel is affordable and does provide the balance between utilization control, individual responsibility, and access to treatment.

Mr. SHERROD BROWN. But for a family with an income of \$30,000 or \$40,000, 50 percent over a period of 30 weeks is a significant amount of money.

Ms. FEDER. Mr. Brown, I think that this gets to the issue of having to phase in the full mental health/substance abuse benefit, and that we have not been able to do for everyone in this area what we might wish to do from the outset.

As we indicated earlier, as the capacity to provide these services in an integrated delivery system expands around the country, we

would expect that we will be able to alleviate those limits, and that is our intent and commitment in the legislation.

Mr. SHERROD BROWN. So this is 30 weeks? 35 weeks?

Mr. ARONS. 30 visit.

Mr. SHERROD BROWN. 30 visit. So the 30-visit, 50 percent copay is seen as temporary, is seen as short-term, long-term, it will scaled back to a copay more consistent with the rest of the health care package?

Mr. ARONS. Well, there are two changes that are possible. One is, with the implementation of the more flexible benefits in the year 2001, there would be an elimination of the limits and the copayment, but, in addition, States are encouraged and we hope that some States will take advantage of the opportunity to integrate their systems earlier, and they can provide for more flexible benefits at an earlier time.

Mr. SHERROD BROWN. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Brown.

Mr. Hastert.

Mr. HASTERT. Thank you.

I appreciate you being before us. It is nice to see you again, Dr. Feder. We know the hard work that you have done to put together the President's health care plan. From the very beginning you were out there working and putting all those pieces together, so I know of your intricate knowledge of this.

You said something in your testimony a little bit ago; you said without limitation in health care, without limitation, but yet one of the things I am trying to understand when I go through this book and others is, you have a trade-off system. I don't know if I know all of the intricacies of this yet because it looks pretty complicated.

But if somebody chooses, especially if a mental health patient chooses, or his doctor chooses to trade off inpatient days for outpatient days, I guess there is almost a four to one trade-off. But let's use a specific situation. Let's say that you are a psychotherapist and you have a patient who is in need of frequent psychotherapy, and you and the plan decide to trade all your patient's inpatient hospital days for psychotherapy visits at the four-to-one ratio.

During November your patient has a complete nervous breakdown and must be hospitalized. However, you and the plan now have a problem because all the patient's inpatient hospital benefit has been used. Your patient is not suicidal or a danger to others, what do you do?

Mr. ARONS. I think you do understand the trade-off situation quite accurately, that, in fact, this is——

Mr. HASTERT. I am trying to.

Mr. ARONS. —that this is a provision so that the individual who could be kept out of the hospital for periods of time or could get out of the hospital earlier has available these trade-offs so that there can be an increase in the number of outpatient psychotherapy days available.

Mr. HASTERT. I understand that.

Mr. ARONS. And we wanted to give plans this flexibility so that a continuum of care can be provided and that there could be some

increased outpatient benefits. It is hoped, therefore, that plans will provide some control over that and will retain some inpatient days and not use all the inpatient days by the end of the year for this purpose.

Mr. HASTERT. So are the inpatient and outpatient days cumulative within the plan, or are they capitated?

Mr. ARONS. For example, if you used, say, 20 of those inpatient days for 80 visits, you would still have additional inpatient days remaining as part of your benefit that could be used, and in addition, as you pointed out, in the cases of threat to life, threat to self or others or need for hospitalization to adjust medication or other somatic treatments, there would be up to an additional 30 days available under those circumstances.

But you correctly point out that the wise health plan, the wise clinician, will be working with their client, their patient, to preserve some inpatient days. But this was not specified in the law.

Mr. HASTERT. And those patient days are allocated on an annual basis, right?

Mr. ARONS. That is correct.

Mr. HASTERT. So in November when this person does have a nervous breakdown and he doesn't have any days left for inpatient hospital treatment, because they have been used for outpatient treatment, what happens? Does he still have a benefit?

Mr. ARONS. Again, depending on the individual, there are still opportunities for brief clinical visits for medication management, there are still opportunities in cases for crisis intervention.

You are painting the picture of someone who is not so severe as to be in need of hospitalization because of a threat to themselves or others, so hopefully there can be some maintenance through case management and other outpatient services through the end of the year, and then, as you point out, at the beginning of the year, a new round of benefits.

Mr. HASTERT. So we have really kind of an inexact science here. Is that is that what you are saying?

Mr. ARONS. That is probably true.

Mr. HASTERT. OK.

The trading system that we are talking about assumes that the spectrum of mental health services are interchangeable. If you are psychotic and need to be hospitalized, how can outpatient psychotherapy possibly be substituted for hospital care?

Mr. ARONS. I think you are correct, there are a variety of mental illnesses, and there are some quite severe mental illnesses that individuals believe can be helped through outpatient treatment in balance with inpatient hospitalization.

But for the individual with the most severe illnesses, the psychotic illnesses, really the required treatment is probably some combination of inpatient hospitalization where necessary, alternative intensive treatments where possible, medication where indicated, some psychotherapy, and we hope that the balance that we have provided does focus on those individuals as well as other individuals.

Mr. HASTERT. Thank you.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Hastert.

Dr. Feder and Ms. Austein and Dr. Arons, the three of you and Dr. Brown earlier represent the administration, and Mr. Cooper said that some of us seem frustrated about the proposal or have questions about it and we are asking some critical questions.

But don't misunderstand the critical questions we are asking. We are asking these questions because we are trying to get answers. But we know what you are trying to do, and it is a wonderful thing. You are trying to get every American universal coverage, every American a set of comprehensive health benefits, including mental health and substance abuse.

Now these benefits cannot be without any limit because we can't give everybody everything, and we want to decide what limits are appropriate, unlike Mr. Cooper's bill which wouldn't give people universal coverage in this Nation.

So let us clearly understand, if we are critical, if we are asking critical questions, we are not being—at least some of us are not being critical of what you are trying to do and not supportive of your efforts.

Mr. Cooper talked about Federal Express where they don't have limits on mental health benefits. Wouldn't you expect that if you have middle class people working for Federal Express, it would be a lot different than when you cover the homeless and others who are without insurance now, who need intensive mental health benefits, that perhaps if we are going to cover all those people, that we have to set up some limits?

Mr. ARONS. Yes, we do think we can learn quite a bit from Federal Express and the approach that they are taking, which is basically to provide for a flexible benefit in which a health plan, providers, and the individual work out the appropriate array of services for the individual, is ultimately, and in the future the way to go for the entire range of individuals, from individuals who are working to those who are homeless and everyone in between. So we do aim in that direction.

We do think, clearly, the kinds of services that need to be available do run across a range and we need some time to put that into effect.

Mr. WAXMAN. We also want to be sure that the American people are not going to be perceiving themselves worse off under health care reform than they are today, and I think that is tremendously important if we are going to have support for this legislation.

People who have good health insurance aren't going to want to find themselves having to pay more or lose that health insurance. I fear this may be the result of some of the proposals; especially if tax deductibility is changed. We also don't want to find that people who are expecting to have health insurance coverage don't get picked up; that they have it offered to them but then they don't really get coverage because they can't afford it.

Then, on the other hand, we have some people that have programs like Medicaid available to them now, and as I understand the administration's mental health benefit, it will be less comprehensive than some State Medicaid programs. Is that a correct statement?

Ms. FEDER. It is correct for the children. It is incorrect for the adults, because they don't have institutional coverage right now,

and it is for that reason, as you know, we have taken some extra steps in that regard.

Mr. WAXMAN. Can a low-income individual remain under their Medicaid plan, or must they first exhaust their health security benefit, and, if so, what happens if they are unable to meet the copayment requirements? Are you confident that a Medicaid eligible individual will be able to afford the out-of-pocket costs of your plan?

Ms. FEDER. Mr. Chairman, as you know, we have made an enormous effort to integrate the Medicaid population and all Americans into the same system, and so the population, the cash assistance population, has the same choice of health plans as other Americans, and so they would receive their benefits through that mainstream system.

We have provided some particular cost-sharing protections for the population on cash assistance, extensive discounts with respect to their cost-sharing; and with respect to the most costly services, the residential treatment, for example, on mental health that was raised, in low cost sharing plans there is no cost sharing.

Mr. WAXMAN. You testified that the President's bill invests in enabling services such as transportation and outreach. As we will hear from a subsequent witness, these enabling services are essential if the core benefit package is to work for low-income and disadvantaged Americans.

Under the President's bill, however, enabling services are not part of the core benefit package. That means that employer and individual premium payments as well as Federal premium subsidies are not available to pay for these services. Instead, the bill authorizes \$1.2 billion over the 1996 to 2000 year period for grants to community health groups to provide such services.

The problem, of course, is that these authorizations are subject to the appropriations cap. As a result of the budget reconciliation bill we enacted this summer, these caps did not allow for any inflation in domestic and defense discretionary programs over the next 5 years. Thus, existing programs will have to be cut about \$78 billion below the President's budget over the next 5 years.

In these circumstances, isn't it unrealistic to argue that the President is investing in enabling services, and which existing defense or domestic programs do you propose to cut in order to make room for the \$1.2 billion in enabling services under the appropriations cap? And if the funding for enabling services doesn't materialize, how likely is it that the poor and underserved will be able to access the benefits for which they are covered?

Ms. FEDER. Mr. Chairman, as you know, the Health Security Act as introduced does not include amendments to the Budget Enforcement Act that would adjust that cap, but I believe you also know that we are committed to making the appropriate expenditures for which we have identified the authorizations in order to ensure that those services are there, and we know that we need to and expect to continue to work with you to find a mechanism to ensure that those dollars are there.

Mr. WAXMAN. Thank you.

I do want to recognize members who want to ask a second round.

Mr. Hastert.

Mr. HASTERT. Yes. I guess some of us sound like a broken record when we talk about costs and trying to find costs, but we are trying to balance the budget and be fiscally responsible here.

One of the things that troubles me—and of course we don't have all your solid numbers yet obviously, but, you know, there are some fudge factors here, mostly when we look at what your total budget is in 1996. It starts with 1.5 percentage points in 1997; 1 percentage point growth in 1998; there is 0.5 percentage in 1999; and for 2000 there is zero percentage points, CPI.

A lot of the programs become effective in the year 2001. Yet 2001 is outside the Congressional Budget Office purview, so none of this stuff gets scored. But we need to look at that and know what those numbers. Are you going to include those numbers when you start to talk about implementation?

I mean there are games that everybody could play on this. I know that you don't want to play those kinds of games, but we need to know what is outside that CBO window also.

Ms. FEDER. I understand your concerns, and first let's put this in perspective. The only benefits that are being phased in, that are not fully in place at the beginning, have to do with the mental health and substance abuse area and some of the dental benefits for adults so that there is only a small area where we are not starting out with the benefit we will also have in 2001.

We expect to continue to work on the estimates for that package, taking into account that we expect there will be major changes in the capacity of the delivery system to ensure a more efficient delivery of those services as well as, as we indicated—

Mr. HASTERT. You mean increase the capacity?

Ms. FEDER. To do it affordably, to increase the capacity to do it in a coordinated fashion, so that it does not lead to a significant hike in premiums. That is our concern.

A key element of that is integrating, as we indicated, the public system for provision of mental health and substance abuse benefits with the insurance system. Many would argue, as the working group did, that if we integrate those dollars, that there are sufficient dollars in the system to provide the integrated package, but we need to develop the mechanisms and coordination to achieve that objective, and that is what we expect to do between now and the year 2001.

Mr. HASTERT. When Secretary Bentsen and Secretary Reich were before us, one of the questions that we were asking, dealt with utilization. They said, "Well, you know, we have no way of knowing what utilization is going to be." I am not sure if that was an accurate answer or not, but I suppose that is somewhat accurate. Is that correct?

Ms. FEDER. I think that it is legitimate to recognize that there is always some uncertainty, but I think it is also legitimate to recognize how much information we do have on utilization of services and we are drawing on that.

We also are changing dramatically the incentives of the health care system, which is perhaps most critical in this regard, in order to give doctors and other practitioners an incentive to deliver—to focus on the delivery of quality care efficiently, and that change in incentives has a dramatic impact on moving utilization in the di-

rection of appropriate rather than inappropriate utilization and leads to savings at the same time that we expand benefits.

Mr. HASTERT. Fine. So when all this is said and done, even though a lot of this that we see coming to development and utilization—you say you have a good handle on what utilization is going to be, and even if it is beyond, you know, 2001 we are going to get those numbers and those estimates as well, right?

Ms. FEDER. Yes, but I want to be clear so that your frustration doesn't increase. The first set of numbers that—you will anyway?

Mr. HASTERT. No. I am very calm.

Ms. FEDER. The initial numbers are for the period through the year 2000, and then subsequently the additional information will be provided.

Mr. HASTERT. Thank you.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Hastert.

Mr. Kreidler.

Mr. KREIDLER. Thank you, Mr. Chairman.

I would just like to say that I very much want to associate myself with the comments that you offered, Mr. Chairman, about the limits on mental health and substance abuse benefits.

I think it is too easy to criticize these limits without putting it into some sort of perspective here, that some of the critics don't support any guaranteed benefits—none, zero, zip, to anyone. You are trying to provide these benefits to Americans at a price we can afford, and I want to commend you for it and commend you, Mr. Chairman, for bringing this to the attention of the committee.

Ms. FEDER. Thank you, Mr. Kreidler.

Mr. WAXMAN. We want to thank you very much for being with us and helping us deal with these issues. As usual, you have been as forthright as you possibly can be, and we still have questions, as you do, and we will have to continue working together to resolve these issues.

Ms. FEDER. Thank you, Mr. Chairman. We are committed to that cooperative process. Thank you very much.

[Testimony resumes on p. 206.]

[The following information was received:]

1/5/94

MENTAL HEALTH / SUBSTANCE ABUSE ESTIMATES

Establishing the Baseline

A. Baseline Data

The baseline for the estimates was derived from the Rice et al. (1990)¹ estimates of the costs of alcohol, drug abuse, and mental (ADM) disorders. These estimates are based on utilization and expenditure data and as such exclude administrative costs. Using the estimates prepared by Rice et al which update the 1985 estimates of direct costs to 1990, the following components were subtracted:

- o Research/Support Costs
- o Nursing Home Costs - 90% (which are those accounted for by people 65 years and older)
- o ADM costs that stem from comorbid physical conditions (e.g., a portion of liver transplant can be linked to alcohol abuse). This amounted to \$4.3 billion.
- o Prevention and data development set asides in the federal ADM Block grant. These deductions were \$20.9 million for mental health and \$225.6 million for substance abuse.²

The allocation between alcohol and drug abuse was made according to the distributions reported in the Rice et al study. Costs associated with forensic hospital care in state mental hospitals were also deducted from the state mental health system expenditures. This amounted to \$0.7 billion in 1990.³

¹Rice D.P. et al, "The Economic Costs of Alcohol and Drug Abuse and Mental Illness 1985," Final Report ADAMHA Contract Number 283-87-0007 1990. Rice et al have updated the 1985 estimates to 1990.

² These totals were the 1990 actual allocations under the Block grant.

³ These data were obtained from the National Association of State Mental Health Program Directors.

This yielded an estimate of \$54 billion in 1990 for total ADM costs. A reconciliation with National Health Accounts yielded a similar estimate of approximately \$54 billion dollars in direct costs. (Table 1)

Total expenditures were then divided among sources of payment. Table 2 summarizes the distribution of baseline costs by payer source. Private insurance expenses consists of total spending from private sources estimated by Rice including out-of-pocket payments and philanthropy. Some adjustment was made to the private insurance expenses reported by Rice et al based on more recent data provided to SAMHSA from the Department of Defense.⁴ Medicaid dollars were based on the high estimate of the range identified by Wright and Buck⁵ trended forward to 1990 dollars. The high end was chosen because since 1984 the advent of disproportionate share rules has increased Medicaid payments associated with ADM disorders. The Medicaid total was estimated at \$9.5 billion in 1990. The Medicaid dollars were allocated to Alcohol, Drug Abuse and Mental Health according to the aggregate proportions found by Rice et al. State and local data are based on data from the Center for Mental Health Services (CMHS) Inventory and National Drug and Alcohol Treatment Utilization Survey (NDATUS). Using data from the CMHS Inventory and NDATUS \$2.2 billion was allocated to Medicare. The Veterans Administration share was based on 1990 data from the CMHS' Inventory data and from data on substance abuse care from the VA. An "other" federal category is defined as a residual of federal funds.

B. Population Groups

The total population in 1990 was 248.7 million.

- o 22.1 million Medicaid eligibles in 1990 (CBO calculations 1993)
- o 31.2 million people 65 years and older (Census of Population).

⁴ These data were reported in a memorandum dated April 16, 1993. (copy attached)

⁵ Wright G.E., and Buck J.A., "Medicaid Support of Alcohol, Drug Abuse and Mental Health Services" Health Care Financing Review 13 (1) 117-128 1991

- o 35 million uninsured persons, 16% of whom (or 5.6 million) had a serious mental problem.^{6,7}
- o 160.4 million privately insured population constitutes the remainder

The estimates discussed in this paper focus on three population groups: the privately insured, the uninsured, and a high user population currently served through the public mental health and substance abuse sectors populations. The population figures were used as follows to weight the three components of an estimated premium:

o	Insured	82.0%
o	Uninsured	15.1%
o	High Users	2.9%

C. Baseline Per Capita Estimates

The population groups defined above were used to develop baseline per capita costs for each group. For the privately insured we divided the expenditures estimated from Rice by the size of that group. Costs from the VA, state and local governments and other federal costs were allocated to the uninsured and high users.⁸

⁶ Norquist G., and Wells K., "Mental Health Needs of the Uninsured" Archives of General Psychiatry 48: 476 1991

⁷ This number is consistent with data from the National Comorbidity survey which reports that approximately 23% of those without insurance report any mental disorder. These data were obtained via personal correspondence with Ron Kessler and are available in a draft manuscript by Kessler et al.

⁸ This allocation procedure represents a substantial simplification of the complex relationships between insurance coverage and the use of public programs.

D. Estimating Premium for Privately Insured

The above set of calculations yields a privately insured per capita estimate of \$138. This figure is then further adjusted by \$12 to remove estimated cost of philanthropy⁹, yielding a starting baseline insured premium of \$126.

Starting with the \$126 baseline estimate, the following was done:

$$\$126 * 0.96 * 1.51 * 0.67 * 1.135^{10} = \$138.90 \text{ insured}$$

- o 0.96 to remove 4% of the costs that are associated with prescription drugs. The prescription drug costs were included in the estimates of the drug portion of the benefit package.
- o 1.51 aging data to get 1994 number
- o 0.67 to remove 33% effective coinsurance rate.¹¹
- o 1.135 load for administrative costs

⁹Mental health philanthropy calculation - Data from the 1992 / 1993 "Dimensions of the Independent Sector" reports \$1.86 billion in 1988 for public support (gifts, grants, and contributions) to mental health. The report also indicates that in the health area private philanthropy is approximately 62% of public support. Taking 62% of \$1.86 billion yielded \$1.15 billion in 1988 dollars; aging the data to 1994 dollars yields \$12 per capita for philanthropy. Subsequent to the estimating process it was realized that a 1990 estimate rather than a 1994 estimate should have been used, since the \$138 per capita is for 1990.

¹⁰ For purposes of these estimates the earlier adopted administrative load of 13.5% was used. This will be adjusted to 15% during the re-estimating process.

¹¹The 33% effective coinsurance is derived based on the following factors: (1) the inpatient coinsurance rate is 0.26 because 6 - 7% of inpatient days are for first days which have a deductible, and the coinsurance rate for the remaining days is 20%; (2) The effective coinsurance rate for outpatient services is 0.47, which is derived because 90% of outpatient visits are for psychotherapy which has a 50% coinsurance, and 10% of outpatient visits are for medication monitoring. The inpatient and outpatient coinsurance figures are then weighted based on the distribution of costs: 0.65 for inpatient and 0.35 for outpatient ($0.65 * 0.26 + 0.35 * 0.47$) yielding a 33% effective coinsurance rate overall.

E. Estimating Premium for the Uninsured

For purposes of estimating the costs associated with the 35 million uninsured population, the group was divided into the seriously ill/high user category (16%) and the remaining uninsured. Epidemiological data (Norquist) suggest that 33% more uninsured than insured have serious psychiatric disorders (roughly 16% of the uninsured have a serious mental illness while about 12% of the insured have a serious disorder).¹² To explain Norquist's results it was assumed that the mental morbidity curve of the insured would have to be shifted rightward for the uninsured population to give a 33% higher morbidity at the tail; that is utilization for the entire uninsured population, and not just the high users, was assumed to be higher.

The uninsured premium estimate was calculated by adjusting the insured premium number by 33%:

$$\$138.90 * 1.33 = \$184.73 \text{ uninsured}$$

F. Estimating the Baseline for the High User Premium

For purposes of estimating a high user premium, the baseline starting point used was current public sector spending which is discussed in A. above. Specifically the state and local spending (\$15.9 billion) and the Federal sources spending (\$4.2 billion) were used for an estimated total public sector spending of \$20.1 billion in 1990. For purposes of these calculations Medicare and Medicaid sources were excluded.

Public sector spending was divided into inpatient and community based care.

¹²Norquist G., and Wells K., "Mental Health Needs of the Uninsured," Archives of General Psychiatry, 48: 476, 1991.

Inpatient

Mental Health U.S. 1992 reports that 58% of state funds are for state mental hospitals. Using the \$20.1 base gives a figure of \$11.66 billion for inpatient care. Calculation of the portion of the public sector dollars for inpatient care that should be excluded from the premium was done as follows:

- o National Association of State Mental Health Directors (NASMHD) March 15, 1993 memorandum indicates that 21.4% of state inpatient expenditures are for 60 or fewer days. (copy attached)
- o $11.66 \times .786 = \$9.2$ billion should be excluded for stays over 60 days

Community-based services

Community based care is estimated to account for \$8.44 billion in costs. The estimate assumed that 30% of the community-based resources would need to be excluded from the premium estimate. The following information contributed to this assumption:

- Ohio reported that 12% of community based expenditures were for Forensic related care which will remain with the public sector (e.g., halfway houses, counseling, residential).
- Ohio reports 7% administrative costs
- NASMHD data report 7% of dollars are associated with case management. The State of Ohio reports 4% associated with rehabilitation and 12% with case management. This is similar to the Medicaid experience of 9% for these two types of services.
- Partial hospitalization (120 days) and residential treatment (30/60) services both have limits, with the assumption being that public sector resources will continue to fund services beyond the limits. NASMHD reports that 12% of expenditures are associated with partial and 17% with residential. Mental Health U.S. reports the median days of stay in partial care as 115, with individuals with schizophrenia having a median of 153 and accounting for 32% of admissions to partial programs.

Assuming a total of 30% for non-covered community-based services and activities:

$$\$8.44 \text{ B (community based care)} \times .30 = \$ 2.5\text{B to be excluded}$$

Combining the inpatient and community-based services exclusions yielded the following estimate:

$$\$2.5 + 9.2 = \$11.7 \text{ to be excluded or 58\% of public spending}$$

Erring on the conservative side a 55% figure for portion of public dollars to be excluded was picked.

Portion of Public Funds Devoted to High Users

Diagnostic data from U.S. Mental Health 1992 indicates that 80% of inpatient admissions to state and county mental hospitals are for serious mental disorders. However, use of an 80% factor would yield a dollar allocation to the uninsured population that would be counter intuitive (i.e., spending that is higher than when covered by insurance). While high users constitute only 80% of public sector users, they likely constitute much more than 80% of public spending. Thus, 90% of public sector resources were assumed to be associated with high users.

Calculation of High User Premium

The calculation of the high user premium was as follows:

$$\$20,100 * 0.9 * 0.96 * 1.45 * / 5.6 = 4496.66$$

$$4496.66 * 1.51 * 1.135 * 0.45 * 0.67 = \$2,323.54 \text{ high user}$$

- o 20,100 total public sector spending, excluding Medicare and Medicaid
- o 0.9 assume 90% goes to high users
- o 0.96 excluding 4% for drugs

- o 1.45 assume 45% increase as a result of plan¹³
- o 5.6 million uninsured are seriously ill
- o 1.51 aging data to get 1994 number
- o 1.135 loading by 13.5% for administrative cost¹⁴
- o 0.45 since 55% of public spending estimated to be excluded under plan
- o 0.67 to remove 33% effective coinsurance rate

G. Philanthropy

It was assumed that health reform would reduce philanthropy by half. It was also assumed that philanthropy would increase by 5% annually so in 1994 the \$6 would grow to \$7.29. However, the rate of growth for services is more than twice that of philanthropy. Thus, it would take \$18.12 in 1994 to cover the same amount of services covered by the \$12 of philanthropy in 1990. The difference of \$10.83 per currently insured (or \$8.88 per enrollee) would need to be made up by the plan. Loading by 13.5% and removing 33% coinsurance gives:

$$8.88 * 1.135 * 0.67 = \$6.75$$

¹³The 45% is based on the assumption that with health reform the cost of the covered services which the public sector will provide would increase to roughly the average of the top 10 states. Since the cost will no longer be limited by the local tax base but would have the entire nation to draw from, poorer states would be able to increase their spending on services covered under health reform. This would result in a 60% increase in national per capita state and local spending. This figure was discounted to 45% to take into account geographical variations other than higher utilization that might partially explain the top 10 states higher mental health spending.

¹⁴For purposes of these estimates the earlier adopted administrative load of 13.5% was used. This will be adjusted to 15% during the re-estimating process.

H. Calculation of Overall Premium

The various population group premiums are then weighted and combined with the philanthropy calculation to yield a total premium estimate:

Population Group	Premium	Weights	Weighted Premium
Insured	138.90	82.0%	113.90
Uninsured	184.73	15.1%	27.89
High User	2323.54	2.9%	67.38
Subtotal			209.17
Philanthropy	6.75	100.0%	6.75
TOTAL:			\$215.92

Estimated change when moving from 30 to 60 day benefit is \$50. We used 50% of this difference for the estimate assuming aggressive utilization review.

$$\$215.92 + \$25 = \$240.92 \text{ rounding to } \$241 \text{ per capita}^{15}$$

The methodology we are using for the estimates under the Health Security Act risk rates premiums by health insurance policy type. Under this approach there is a difference between per capita costs across the nation, and the costs for risk pools within different types of insurance policies.

In order to move to an estimated premium, we pooled singles and couples with no children and calculated a per person premium based on the characteristics of individuals in this risk pool. Single parent families define their own risk pool, as do dual parent families. Under this methodology, a single policy is estimated to have \$285 in mental health and substance abuse costs, a couples policy \$570, a single parent policy \$567, and a dual parent policy is estimated to include \$636 for those same benefits. In the context of the overall premium estimates, mental health and substance abuse accounts for approximately 15% of the total premium.

¹⁵ Approximately 20% of per capita is for substance abuse. (20% of \$241 = \$48, or approximately \$50).

TABLE 1: NATIONAL HEALTH ACCOUNTS
DIRECT COST OF ADM DISORDERS
UPDATED TO 1990 (IN MILLION \$) (5/10/93 rev.)

	ALCOHOL ABUSE	DRUG ABUSE	MENTAL ILLNESS	TOTAL
TOTAL DIRECT COST	\$10,142	\$3,156	\$64,201	\$77,499*
ADM ORGANIZATIONS	\$ 3,656	\$1,291	\$19,516	\$24,463
SHORT STAY HOSPITAL	\$ 4,032	\$1,424	\$10,593	\$16,049
OFFICE BASED PHYSICIANS	\$ 240	\$ 88	\$ 3,655	\$ 3,983
OTHER PROFESSIONAL SERVICES	\$ 329	\$ 32	\$ 6,599	\$ 6,960
NURSING HOMES	\$ 1,095		\$16,478	\$17,573**
DRUGS			\$ 2,191	\$ 2,191
SUPPORT COST	\$ 790	\$ 321	\$ 5,169	\$ 6,280**

*Excludes \$4.3 billion direct cost for treatment of co-morbid physical disorders.

**Excluding 90 percent of nursing home costs for those 65+ years. Research/Support Costs, \$0.7 billion for continued State Forensic Psychiatric Services, and \$0.4 billion for prevention and data collection portions of the SAMHSA block grant (25 percent), leaves a total base of \$54.3 billion Direct Treatment Costs for Mental Health and Addictive Disorders (1990).

TABLE 2
AGGREGATE DISTRIBUTION OF BASELINE FUNDS FOR SUPPORTING
THE COMPREHENSIVE MENTAL HEALTH AND
SUBSTANCE ABUSE BENEFIT
(IN BILLIONS)

	1990	1994
Private Insurance	\$22.2	\$28.0
Medicaid	\$ 9.5	\$12.0
Federal	\$ 5.3	\$ 6.7
State	\$ 4.2	\$ 5.3
Federal Sources	\$ 4.2	\$ 5.3
VA	\$ 2.3	\$ 2.9
Block Grant	\$ 1.0	\$ 1.2
Other	\$ 1.0	\$ 1.3
Medicare (excluded)	\$ 2.2	\$ 2.8
State and Local	\$15.9	\$20.1
State	\$13.0	\$16.5
Local	\$ 2.9	\$ 3.6
Total	\$54.0	\$68.2

APRIL 16, 1993
SUGGESTED CORRECTIONS TO SUBSTANCE ABUSE (S.A.)
EXPENDITURE DATA FROM MODEL
the following data were presented:

	HOSPITALS		S.A. TREATMENT ORGANIZATIONS		ALL OTHER PROVIDERS		TOTALS
CATEGORY	\$MIL	%	\$MIL	%	\$MIL	%	\$MIL %
PRIV HI	\$1,632	37.1%	\$1,113	22.5%	\$301	43.7%	\$ 3,047 30.4%
MEDICAID	\$ 814	18.5%	\$ 411	8.3%	\$139	20.2%	\$ 1,364 13.6%
ST & LCL	\$ 977	22.2%	\$3,037	61.4%	\$151	21.8%	\$ 4,165 41.5%
VA	\$ 35	0.8%	\$ 20	0.4%	\$ 0	0.0%	\$ 55 0.5%
MISCELL	\$ 330	7.5%	\$ 317	6.4%	\$ 75	10.9%	\$ 722 7.2%
MEDICARE	\$ 612	13.9%	\$ 49	1.0%	\$ 23	3.4%	\$ 684 6.8%
TOTAL	\$4,400	100.0%	\$4,947	100.0%	\$689	100.0%	\$10,036 100.0%

The corrected data should be:

	HOSPITALS		S.A. TREATMENT ORGANIZATIONS		ALL OTHER PROVIDERS		TOTALS
CATEGORY	\$MIL	%	\$MIL	%	\$MIL	%	\$MIL %
PRIV HI	\$1,976	36.2%	\$1,113	22.5%	\$301	43.7%	\$ 3,390 30.6%
MEDICAID	\$ 814	14.9%	\$ 411	8.3%	\$139	20.2%	\$ 1,364 12.3%
ST & LCL	\$ 975	17.9%	\$3,037	61.4%	\$151	21.8%	\$ 4,163 37.5%
VA	\$ 751	13.7%	\$ 20	0.4%	\$ 0	0.0%	\$ 771 6.9%
MISCELL	\$ 330	6.1%	\$ 317	6.4%	\$ 75	10.9%	\$ 722 6.5%
MEDICARE	\$ 610	11.2%	\$ 49	1.0%	\$ 23	3.4%	\$ 683 6.2%
TOTAL	\$5,456	100.0%	\$4,947	100.0%	\$689	100.0%	\$11,092 100.0%

Documentation:

1. PRIV HI/HOSPITALS includes \$344 million for inpatient treatment of substance abuse of military personnel in military hospitals (this was not captured in the NCHS National Hospital Discharge Survey); source - the Department of Defense (Health Affairs).
2. The VA/HOSPITALS has been corrected (this was not captured in the NCHS National Hospital Discharge Survey; the dollar amount is for the substance abuse treatment only in VA hospitals); source the Veterans Affairs (Mental Health).
3. CMHS, has said that there should be almost no overlap in dollar amounts between its data source inventory and the DoD and the VA.

Mr. WAXMAN. From our next panel we will receive testimony on the impact of the proposed substance abuse benefit. Stan Lundine is the Lieutenant Governor of New York State. Rebecca Crowell is the executive director of Nexus, Inc., a substance abuse treatment program for women in Dallas, Tex., and Valerie Howell is a former Nexus client and the mother of a 5-year-old.

I want to welcome the three of you today.

We are appreciative of the fact that you have been willing to come here and help us better understand the impact of the President's proposal on the availability of substance abuse treatment.

Without objection, your prepared statements will be in the record in full. What we would like to ask each of you to do is to summarize or deliver the oral testimony in no more than 5 minutes, and we will have an opportunity for questions and answers.

Mr. Lundine, we particularly are pleased to see you as a former colleague back here in Washington, and we have noted the good work you are doing in New York. Thank you for being here.

STATEMENTS OF STAN LUNDINE, LIEUTENANT GOVERNOR, STATE OF NEW YORK; BECCA CROWELL, EXECUTIVE DIRECTOR, NEXUS, INC.; AND VALERIE HOWELL, DALLAS, TEX.

Mr. LUNDINE. Thank you, Mr. Chairman, and thanks for the opportunity the present testimony on behalf of the State of New York regarding the implications of health care reform on our substance abuse treatment system.

In 1989, Governor Cuomo asked me to head up our Anti-Drug Abuse Council. Today, 4 years later, while we have made some progress, we still face a crisis. Recent statistics show that, after a period of some success, heroin and cocaine use are rising again.

To address the problem, New York has the largest drug and alcohol treatment system in the country. Today, we are treating 100,000 people, 20,000 more than we were when I first took this responsibility 4 years ago. But there are many users who have not been reached. Nationally, there are 2 to 3 million American drug abusers who are not getting treatment. This year in New York, we will spend over \$22 billion on Medicaid funds, and drug and alcohol abuse are one of the reasons that our costs are so high.

Let me say parenthetically that as we set about creating a new and universal health care financing system, we also should make it a priority to distribute Federal aid in the Medicaid program more fairly. The President has taken an important step in including substance abuse benefits in his health care reform plan. Recognizing that drug and alcohol abuse is one of our Nation's top public health problems is a crucial step toward controlling overall health care costs.

However, while the President's proposal will expand treatment for some Americans, it could actually reduce the quality and level of treatment available for those who have the most serious and chronic addictions. Worse still, by cutting back on the Federal substance abuse block grant to offset some of the costs of the reform, the plan risks eliminating even the limited safety net that now exists.

We think there is a need for more comprehensive coverage. The substance abuse benefit in the current legislation provides a maxi-

mum of 30 days residential care and 120 days outpatient counseling visits. That may be OK for people like you and me who have families, who have jobs, and that kind of thing, but chronically addicted drug abusers are not cured in 30 days residential treatment. Mentally ill chemical drug abusers are not helped when the mental illness and the substance abuse are treated as one when they are actually medically separate problems.

Therefore, we need to maintain the block grant for hard-core drug abusers, and that was mentioned by Lee Brown and the administration in their interim drug strategy report, that they wanted to target treatment to hard-core drug users, but unfortunately this proposal will work against that.

While they have said that as much as 65 percent of the people who are treated under the block grant will be helped by this health insurance coverage, our estimate is that only a very small percentage of the people that we actually treat with the funds of the block grant will be covered under the national health program.

You can ask, well, then, where do you get the money from? And I know the institutional and political problems, having served for more than 10 years in this House, and I respect it deeply, and I know some of your problems. But the simple fact of the matter is, we are spending a \$1.1 billion in the Pentagon to try to stop drugs coming into the country; we are spending \$1.5 billion today fighting drug production in the Andes, and that doesn't even count the Coast Guard and Customs Service who are spending probably another billion dollars, and it is making no impact on either the availability or the price of drugs in New York. Even Attorney General Reno has acknowledged that that effort is not working. So if we could take the money out of the interdiction, even a billion dollars, we could double our treatment capacity.

Thank you very much, Mr. Chairman.

[Testimony resumes on p. 218.]

[The prepared statement of Mr. Lundine follows:]

TESTIMONY OF LT. GOV STAN LUNDINE
STATE OF NEW YORK

BEFORE

HOUSE ENERGY AND COMMERCE COMMITTEE
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

DECEMBER 8, 1993

Thank you for the opportunity to present testimony on the implications of health care reform for New York's substance abuse system.

Putting New York's Drug Treatment System in Perspective

In 1989, Governor Cuomo established the Anti-Drug Abuse Council to develop a strategy to fight drug abuse in New York state. I chair that council. At that time we were facing an unprecedented national drug crisis.

Today, almost four years later, we still face a crisis. In fact, recent statistics show that, after a period of some success, heroin and cocaine abuse are rising again. The 1993 National Drug Control Strategy Report indicates that the number of drug-related deaths and medical emergencies was higher in 1992 than at any time since we started collecting this information.

In New York we estimate that nearly 900,000 New Yorkers use illegal drugs regularly, and more than 1.5 million abuse alcohol.

New York has done more than any other state to address the problems associated with drug and alcohol abuse. Today New York has the largest drug and alcohol treatment system in the country. We treat more than 100,000 people daily -- 20,000 more each day than we were treating in 1989.

But despite the size and cost of our system there are many hard-core drug users we haven't reached. Of course, New York is not unique in this respect. Nationally we estimate that 2-3 million Americans need drug or alcohol treatment and aren't getting it.

This year New York will spend over \$22 billion in Medicaid funds. Drug and alcohol abuse are part of the explanation of our costly program.

The American Medical Association reports that 25 to 40 percent of all hospitalizations are direct result of substance abuse related illnesses. Similarly, a recent report by the Center for Alcohol and Substance Abuse found that \$1 out of every \$5 spent by Medicaid nationally is attributable to addictions.

Without a strong national commitment to fight addictions, states like New York will continue to face a disproportionate burden. For example, we estimate that today New York has at least half the nation's heroin abusers. As a direct result of drug abuse we also face higher incidence of other health problems; for example, New York has more than 20 percent of the nation's AIDS cases, and is the epicenter of the tuberculosis outbreak. New York has over 16% of the TB cases nationally.

Today I want to focus specifically on the implications of the President's plan for New York's drug and alcohol treatment system.

The President has taken an important step forward by including substance abuse benefits in his health care reform plan. Recognizing drug and alcohol abuse as one of our nation's top public health problems is crucial to controlling our health care costs.

However, while his proposal will mean a genuine expansion of

treatment for some Americans, it may well reduce the quality and level of treatment available for those with the most serious and chronic addictions. The plan's limits on lengths of stay and number of outpatient visits, high cost sharing requirements, and strict utilization review standards mean that those people who are most in need of treatment -- and impose the highest costs on society when they are not treated -- will not be getting the care they need.

At the same time, by cutting back the Federal Substance Abuse Block Grant to offset the costs of reform, the plan risks eliminating even the limited safety net that now exists for this population. This could spell a human and financial disaster for New York and the entire nation.

Drug and alcohol abuse, AIDS, TB - - these are crises affecting us all. Some states, like New York, however, bear a disproportionate burden in confronting these crises. The Medicaid program does not adequately recognize the unequal burdens facing states because of our disproportionate share of these cases. The distribution of Medicaid funds has not been revised to address the new population it serves. Federal funds should be distributed on the basis of not only a state's ability to pay, but the need and cost of care for special populations.

Need for More Comprehensive Coverage

The substance abuse benefit in the current legislation provides a maximum of 30 days of residential care and 120 outpatient counseling visits.

This plan may be appropriate for people like you and me -- people who are employed, who have a home, who have a fairly stable family or support system, and whose addiction was diagnosed early on.

However, the plan is completely inadequate to address the needs of people who have long-term chronic addictions -- the so-called "hard-core" drug users. This is the very same population the Administration promised to target for drug treatment in the recently published Interim Drug Strategy Report. As that report points out, hard-core users fuel the demand for drugs and impose the greatest costs on our health and social services systems.

But almost all hard-core users -- especially those who are pregnant addicted women, women with children, the homeless, or adolescents -- need more than 30 days of inpatient or residential care. For people without stable homes and jobs to return to, long term residential care ranging from six to 18 months is often the only appropriate solution.

Need to Maintain the Block Grant

New York now pays for treatment through a combination of state and local funds, and \$90 million annually from the Federal Substance Abuse Block Grant.

We are concerned that the Administration, based on the more generous benefits initially proposed, has estimated that as much as 65% of the treatment dollars in the Block Grant and other categorical programs would be offset by the new health care plan.

However, we believe that the Block Grant and the benefits in the health care plan address very different populations. The Block Grant pays for services for chronically addicted people, while the health care plan will serve those who can be helped with much more limited treatment. As a result, only a very small percentage of the services that the Block Grant now provides will be offset by the new health plan.

If the Block Grant is not maintained at its current funding level, states will quickly find themselves forced either to pay for services for those who have exhausted their new health benefits, or to cut services, turning away more addicts who are looking for help.

Because many addicts may only be eligible for limited treatment under this plan, they may also lose eligibility for other social service programs, such as food stamps, Supplemental Security Income, etc. For example, we estimate that New York stands to lose portions of the \$40 million we now receive in the Federal share of Medicaid for SSI and AFDC clients in drug or alcohol treatment, and the \$11.5 million in food stamps, Supplemental Security Income, Medicare, school lunch and Bureau of Prisons funding our treatment system receives. If many addicts are no longer eligible for federal aid, New York will not be able to guarantee them these crucial services.

The bottom line for New York is that the Federal Substance Abuse Block Grant must not be used to offset the costs of reform until a truly comprehensive benefit -- without arbitrary day limits or caps -- has been phased in. The truth is that the Block Grant should be increased if we put a priority on fighting drug abuse. At a minimum it should be maintained at its current level.

If we make the mistake of eliminating the existing safety net without putting in place a real alternative, we can expect dramatic increases in violence, homelessness and demands for federal and state spending for criminal justice, foster care, and social services.

Need to Transfer Interdiction Funds to Treatment

We understand that mental health and substance abuse treatment services are expensive, and that it is crucial to keep down the

cost of the total benefit package. There is, however, an alternative source of funding for treatment.

This year, the Pentagon will spend \$1.1 billion to stop the flow of drugs into America. The Coast Guard and Customs Service spend another billion. And we've spent \$1.5 billion to date fighting drug production in the Andes.

There is widespread agreement -- among academics, members of Congress, the press, and urban police departments across the country -- that these programs are not working. GAO studies have shown for years that interdiction efforts have had virtually no impact on the price or availability of drugs on our streets. Even if we were wildly successful, only a small percentage of drug smugglers would be intercepted. In fact, we would have to multiply our efforts a hundred times before we would have any significant effect on the supply of drugs in this country. Attorney General Reno has acknowledged this publicly.

I realize that there are institutional barriers to changing federal policy in this regard. There are many reasons -- including conflicting committee jurisdictions in Congress -- that make a transfer of funds difficult. Our current policy is dictated by politics, not sound policy.

The fact remains that if we were to step back and examine how best to spend scarce resources, we would conclude that we should move at least \$1 billion of the money we're now spending on interdiction to drug treatment and prevention programs that work. Transferring \$1 billion would double the funds available for drug treatment through the Block Grant.

Need to Separate Mental Health and Substance Abuse Coverage

I would like to share a few specific concerns about how the

substance abuse benefit is structured in the Administration's plan.

The plan combines the coverage for substance abuse and mental health services. For every day a patient is in the hospital for mental illness, he or she is entitled to one less hospital day for substance abuse services should that be necessary. This is like saying a man with lung cancer cannot get hospital care this year because he has already been hospitalized for heart disease.

No other services in the plan are combined this way -- for good reason. While sometimes overlapping, mental health and substance abuse are different medical problems. This arrangement does not acknowledge that someone may have one problem without the other, and is entirely inadequate for those who suffer from both.

This benefit guarantees that those who are both mentally ill and addicted to drugs will not get the care they need. In absolute terms there are not many individuals in this category, although we believe the numbers are growing. But if you read the newspapers you know that these are the people who often present the most serious danger to themselves and to society. They are also the most difficult to get into treatment in the first place. This is the population for which we can least afford to cut treatment.

I might add that as treatment for substance abuse costs far less than treatment for mental illness, the clear effect of merging the benefits will be to divert funds from drug and alcohol treatment to pay for mental health services. Separating these benefits and costing them out independently would make better medical sense and protect those with the most serious and overlapping problems.

Need to Reduce Cost Sharing Requirements

The Administration plan includes high copayments and deductibles for substance abuse services. Even patients who choose a health plan with "low" cost sharing will pay \$10 per outpatient visit, and \$25 per visit for family services or intensive non-residential care that goes beyond 60 days. Patients who do not choose the "low" cost sharing plan will have much higher copayments and deductibles.

To make the situation worse, no expenses that patients pay for outpatient counseling or intensive non-residential care will be counted toward the annual out-of-pocket limit. This is true despite the fact that every other type of health service covered by the plan will count toward the limit.

Imposing cost-sharing requirements on people simply raises a senseless barrier to treatment. Addicts tend to deny that they need help, and research shows that any additional disincentives to seek care, especially those imposed at the start of treatment (such as the deductibles in the high cost sharing plan) will reduce the numbers of people seeking treatment.

To encourage treatment, the plan should treat substance abuse service as it does preventive office visits, which do not require any copayments.

Need for Research and Standards to Guarantee Appropriate Care

The Administration's plan integrates substance abuse services with other health care services. That's the right thing to do. But there are also dangers, especially as we move toward a world of managed care.

The Administration's plan places critical decisions about the level and type of care a patient would receive in the hands of

health plans. This is not unique to substance abuse. However, for other specialized care, such as home health care or occupational therapy, the President's plan designates the provider, not the health plan, as the key decision-maker.

The reality is that many managed care plans still have little experience or expertise with addicted patients. In New York we have experienced significant difficulty developing a plan to assure that the needs of substance abusing Medicaid patients will be met in our Medicaid managed care program. I am convinced that we will, in the end, succeed. Nevertheless, our experience shows that a number of steps may be required to guarantee that care is not denied inappropriately. These measures include rigorous quality assurance, and licensing or credentialing standards for providers and utilization review agents.

In addition, more research is required to develop reliable clinical tools to assess appropriate levels of treatment for different types of patients and to design outcome measures that we can use to evaluate success. While there is much federally funded research on substance abuse underway, we must do a much better job of redirecting our research efforts to guarantee that the results can be translated into tangible improvements in treatment.

Conclusion

The President and Mrs. Clinton have taken a historic step in proposing a comprehensive health care reform plan to guarantee all Americans health insurance. They have also recognized that to improve public health and security, mental health and substance abuse must be included in this plan.

We need to take this commitment one step further and acknowledge that without more generous substance abuse treatment benefit, we

will not be able to reach hard core drug users with this plan.

There is no question that expanding substance abuse treatment services will increase the cost of the health benefit package somewhat. But the costs of not treating addicts -- particularly in increased violence and crime -- are much higher than the cost of treatment.

Just last month, Congress acted on a \$22 billion crime package. I was pleased to see that drug treatment for people in prison was included in that package. But we must reach addicts and treat them before they commit crimes.

Today Congress has an opportunity to improve on the Administration's plan and take the next important steps. With your help, we can guarantee that:

- the benefits for substance abuse and mental health will be comprehensive and will meet the needs of hard core drug and alcohol abusers;
- we maintain the Federal Substance Abuse Block Grant at its current level until we can evaluate the impact of reform;
- we transfer at least \$1 billion of the funds we are not spending wisely in interdiction to drug treatment and prevention programs;
- we restructure the benefit for mental health and substance abuse to: separate mental health from substance abuse coverage, reduce cost sharing requirements, and assure that strict utilization review standards don't prevent appropriate care.

Thank you.

Mr. WAXMAN. Thank you very much, Mr. Lundine.
Ms. Crowell.

STATEMENT OF BECCA CROWELL

Ms. CROWELL. I am the director of Nexus, Inc., which is a community-based treatment program located in Dallas, Tex. We serve the clients you all have been referring to this morning, the hard-core addict, indigent female drug addicts. We have over 100 residential beds for single adult women, women with their young children, and more recently for pregnant women and their drug-exposed infants. We served 514 clients last year and over 6,000 clients, all women, in our history.

Nexus treats clients for an average of about \$64 a day. Before I came to Nexus, I worked in private for-profit hospitals managing drug treatment units where we treated patients for about upwards of \$1,000 a day. Aside from the occasionally medically or psychiatrically complicated patient who really needs hospital care, those patients did not get significantly better or different care for \$1,000 a day than our current clients at Nexus receive for \$64 a day in residential treatment.

There are many positive aspects to the substance abuse benefit that is being proposed right now in the American Health Security Act. The inclusion of drug and alcohol treatment in the standard benefit package is great, it is a milestone in and of itself, and recognition of the need to continue community-based delivery systems is important to continue with programs like Nexus that are established and are working because we have achieved easy accessibility and good results, results that aren't often achieved in more expensive systems. We have also developed a model of treatment that I think better addresses hard-core addicts; it includes life skills training.

The administration should be applauded for its vision relating to women's programs and programs for pregnant addicts and their children. However, I am concerned about a few things in the substance abuse benefit, many of which have already been mentioned. By far the most alarming aspect to a provider like me who treats clients for 6 months to a year is this proposed limit of 30 days of residential treatment per episode.

I know from my experience of working with several thousand drug addicts in both short and long-term settings and in hospital outpatient and residential settings, that 30 days of treatment is not enough to make a difference in clients who have lifetime patterns of substance abuse and multiple problems.

For a 32-year-old white or African American woman with an 11th grade education, a poor work history, children, an income of \$4,500 a year, no husband, and cocaine as a drug of choice, 30 days of treatment is simply not enough, and the woman that I just described to you is a profile of a typical client at Nexus. In the first 30 days of treatment, she is still struggling with her own denial about needing treatment, is resistant to everything we are trying to do, and is still wanting to do treatment her way.

In the first month, what we hope to accomplish is to help her become clear thinking, get some commitment to treatment, and begin the process of exposing her to education, support, and a 12-step

program of Alcoholics Anonymous or Narcotics Anonymous, and she and her children begin a routine that includes predictable daily schedules, family rituals, nutritious meals, many of those other things beyond the core focus of drug treatment that are usually absent before they enter treatment.

We don't expect in 30 days to overcome the effects of poverty and unemployment, physical and sexual abuse, poor nutrition, and drug dependence that we see in most of our clients. They typically come together as a package when you are dealing with low-income, long-time drug abusers.

Over the next several months to a year, this client will develop and practice a recovery program, attend parenting classes, participate in vocational training, carry out a job search, and in her final phase of treatment actually work and save money before transitioning out into independent living.

I think the model that we are developing is the model that is really going to work for hard-core, long-time addicts. To effect lasting change in a year is a challenge in and of itself, but to do so in 30 days is impossible.

The model that I have described to you is largely publicly funded. We are supported now primarily by Federal block grant funds that come to the State and then on to agencies like Nexus. We have also recently received a direct Federal grant from the Centers of Substance Abuse Treatment to open the perinatal treatment program.

So I have concerns that those funds will disappear, that there won't be Federal block grant funds, categorical grant funding, because we will feel like we have addressed the problem by having the 30 days of treatment in the basic package. They are two different things and two different needs, and, as he said, 30 days might be sufficient for me—you know, for a particular group—but not for the clients that we see every day and that we work with for 6 months before impacting significant change.

[The prepared statement of Ms. Crowell follows:]

STATEMENT OF BECCA CROWELL

I. Introduction

Thank you for the opportunity to present testimony on the proposed substance abuse benefit in the American Health Security Act. I am the director of Nexus, Inc. a community-based treatment program located in Dallas, Texas, which serves indigent, female, drug addicts. Nexus has over a hundred long-term, residential beds for single adult women, women with their young children, and for pregnant women and their drug-exposed infants. We also offer outpatient day treatment and aftercare treatment for all clients. Nexus served 514 clients in FY 1993 and has served over 6,000 women in our history. Most clients stay at Nexus for four months to a year.

Nexus treats clients for an average of about \$64 per day. Before coming to Nexus 3 and 1/2 years ago I spent several years managing for-profit drug treatment programs within general hospitals. There we treated patients for about \$1,000 per day. Aside from the occasional medically or psychiatrically complicated patient who needed hospital care, those patients did not get significantly better or different care for \$1,000/day than current residents at Nexus get for \$64/day. In fact, the overall impact of treatment was often diminished because their substance abuse benefit was exhausted in a short period, resulting in a short length of stay.

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II. Comments on Substance Abuse Coverage in the American Health Security Act.

A. Strengths

There are many positive aspects to the substance abuse benefit in the American Health Security Act.

- 1) The inclusion of drug and alcohol treatment in the standard benefit package is a significant milestone in itself.
- 2) Recognition of the need to continue community based delivery systems is important, not only because it is a cost-effective way to provide treatment but because community programs have achieved easy accessability and results not often achieved by HMO's, managed care and hospitals. They have also developed more comprehensive models of treatment that include life skills training.
- 3) The administration should be applauded for its vision relating to specialized women's treatment programs and programs for pregnant addicts and their children. These are humane proposals but also cost-saving proposals.

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B. Concerns

However, I am concerned that the substance abuse benefit, as currently proposed, will not achieve the success that could be possible, or the savings, due to several problems in its current structure.

1) Residential Treatment Limits

By far the most alarming aspect of the current proposal is the limit of 30 days of hospital or residential treatment per episode and a 60 day limit per year. Though this may be an appropriate limit for hospital treatment, clients with severe addiction problems need longer stays. I know from the experience of working with several thousand drug addicts in short and long term settings that 30 days of treatment is not enough to really make a difference in lifetime patterns. For a 32 year old white or African-American woman with an 11th grade education, two kids, an income of \$4,500/year, no husband and cocaine as a drug of choice, 30 days of treatment is simply not enough.

The woman I just described to you is the profile of an adult client at Nexus. In the first 30 days of treatment she is still struggling with her own denial about needing treatment, is resistant to the rules and structure that we require and still wants to do

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treatment "her way". In the first month we expect to help her become clear-thinking, become committed to treatment, expose her to education, support from her peers and the staff, and to the 12-step program of alcoholics. She and her children begin a routine that includes predictable daily schedules, nutritious meals, and family rituals - things which are usually absent before entering treatment.

We certainly don't expect in 30 days to overcome the effects of poverty, unemployment, physical and sexual abuse, poor nutrition and drug dependence that so often come together. Over the next several months to a year the women develop and practice a recovery program, attend parenting classes, participate in vocational training, carry out a job search and finally work and save money while still living at Nexus.

I believe that we are developing the model of treatment that really works for hard-core, long-time drug abusing women; not just for high-functioning, stable alcoholics and addicts in early phases of dependency. Nexus effectively changes the lives of women who have serious drug problems; problems often fueled by the hopelessness that results from multiple

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handicaps such as poverty, abuse, welfare dependence, and legal problems. To affect lasting change in a year is remarkable, to do it in thirty days is impossible.

2) Levels of Funding

The Nexus model that I have described to you is largely publically funded. We are supported primarily by Federal Block Grant Funds which are awarded to the state for dissemination to community based treatment programs. Nexus also recently received a direct federal grant from the Center for Substance Abuse Treatment to open the pregnant/postpartum program.

While the Administration has stated that the publicly funded system will remain in place for the provision of care not covered under the benefit package, treatment providers are concerned about whether sufficient public funds will actually be available. To the extent that a comprehensive substance abuse treatment benefit is not included in the plan it is imperative that current federal block grant and categorical grant programs be retained and that states be required to maintain their funding levels for drug/alcohol treatment.

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3) Disincentives

We are also concerned that the accessibility we have worked so hard to achieve; which is in fact a hallmark of community-based programs, will be impacted by measures designed to discourage usage. Co-payments, utilization review and length of stay limits may make sense as a way of limiting unnecessary usage of the mental health benefit. It does not make sense when applied to chemical dependency... a disease whose primary symptom is denial and where underutilization is more of a problem than overutilization. It does not make sense when treatment of the problem saves lives and dollars related to AIDS, fetal alcohol syndrome, infant complications resulting from drug exposure, cirrhosis, and other medical conditions related to substance abuse; not to mention accidents and violence related to drugs and alcohol.

C. Consequences

Multiple studies document that the costs of not treating drug and alcohol problems are much higher than the cost of treating them comprehensively. By not providing relatively inexpensive treatment to

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addicted mothers today we assure their need for more expensive services later, for themselves and their children.

III. Recommendations

As someone who has devoted my professional career to treating alcohol and drug addicts in both profit and not-for profit settings, in hospitals, residential and outpatient settings, I strongly recommend the following:

- 1) providing a wholly separate, comprehensive, drug/alcohol treatment benefit which offers a continuum of care, including long-term residential treatment.
- 2) supporting community-based treatment providers and identifying us as essential providers.
- 3) preserving Federal and State funds to whatever extent is needed to supplement the treatment covered in the standard package.
- 4) eliminating disincentives to accessing drug treatment, since we know that money saved on drug treatment will be spent many-fold in other parts of the medical and social service systems.

Thank you for considering my views. I believe they are representative of the views of other providers of residential substance abuse treatment. I am happy to be available as a resource to you as Congress continues to define health care reform.

Mr. WAXMAN. Thank you very much, Ms. Crowell. We appreciate your testimony.

Ms. Howell.

STATEMENT OF VALERIE HOWELL

Ms. HOWELL. Yes. I am a 34-year-old mother who is a recovering alcoholic and drug addict. Each day that I look in the mirror, I still see the person that abused drugs and alcohol for more than 18 years. But because I had a desire to stop and was accepted into Nexus, a treatment facility for women and children, I know that I am not the same person inside today.

In 1990, I admitted myself into an institution for major depression for 60 days, and my 2-year-old child stayed with relatives, and while I was in treatment, my son, Keaton, started regressing back to bed wetting and baby talking, and to this day he has not spoken the same since. It really scares me to think about what happened to him while I was in the hospital those 60 days, or was he just afraid that I wasn't coming back again?

While I was at the hospital, it was suggested that I needed alcohol and drug abuse treatment, but I was too afraid to go, and I was also concerned about who would take care of my child. The counselor told me about Nexus, a place where I could get the help that I needed and that I could take my son, Keaton, with me.

When we got to Nexus in September of 1992, we were lost and I couldn't see any way that I could be rehabilitated. I was so used to the life-style of using, cunning, manipulation, that I thought that we were a hopeless case.

Cocaine and marijuana are my drugs of choice, but there is not a drug that I haven't done in any way that it can be done, and I did anything to get it. I had no parenting skills, low self-esteem, no identity, no self-respect, and not a clue of what a family was like or what it was supposed to be like.

My son was a 4-year-old angry, scared, and abused little boy whose speech was diagnosed at the level of a 2½-year-old. He had never been around very many children and had seen some things adults never see, like drugs, sex, me being abused by men, several different men, and he had been cared for by more than a dozen different baby-sitters.

During the 13 months that we stayed in Nexus, our lives started to change. The first 30 days, my mind and body were struggling just to become adjusted to a routine schedule. For instance, waking up at 6:30 a.m., eating at scheduled times, attending group and individual therapy, spending quality time with Keaton and reading him a bedtime story were some of the hardest things that I had to do, and those days right now are still very foggy to me, those first 30 days.

The longer we stayed, the more things started to become clearer for me. I guess, you know, the drugs were coming out of my system, I was coming to my senses again, and I started learning what it was going to take for me to become drug free. I created a recovery program for myself. I took the parenting classes, the vocational training, and I finally, after several rejections, got a job while I was in treatment.

My son and I, we are a family now, and we continue to live like we learned to live at Nexus. He is enrolled in school in speech therapy, he sees a counselor, which was recommended by Nexus at the child guidance clinic, for his anger and the abuse he suffers from, and he has been going there for a year now. He also has a Big Brother, which the clinic helped us get, and he is learning to learn to trust that I will take care of him and that maybe I won't go away and stay for days like I used to.

I haven't used drugs since July 26 of 1992, and I live one day at a time. I have also turned my will and my life over to the care of a power greater than myself whom I choose to call God today.

I thought that I couldn't have women friends and that no woman could relate to me, but I found that I am just one of the many women that suffer from this disease or addiction.

The one thing that we all have in common is that we have a desire to stop or we want a chance to learn how to stop using and how to be a better parent and to go back into this world full of temptations and not use drugs again.

I am becoming a better parent because of the 6 months of parenting classes and parenting skills Nexus taught as part of the treatment. My self imagine is better. I still have the same job that I got when I was in treatment working with a local cosmetic company. I am in group therapy on a weekly basis, and I participate in the aftercare programs offered at Nexus, and I am also involved in the Nexus Exes alumni group. I am very active in Narcotics and Alcoholics Anonymous, and I am also in the incest survivors group held at the treatment facility.

The most important thing that I got from treatment was the opportunity to see what a family was like. We were given the chance to experience what unconditional love really is, and I was taught the difference between discipline and punishment. I still look like that same person today, but my mind has new messages recorded in the past 13 months, and I know that the door is always open for me at home, Nexus.

Thank you.

Mr. WAXMAN. Thank you very much, Ms. Howell. I think it probably took a lot of courage for you to come here to Washington to tell us your personal story, and I am sure your son, Keaton, is very proud of his mother.

You were at Nexus, and looking back at that experience, what would have been the effect of limiting you and your son's stay to the 30-day residential care limit proposed in the President's plan? Would you still have been able to obtain parenting classes and learn the skills necessary to find and hold a job?

Ms. HOWELL. I don't think so, because the first 30 days my body was just coming off the drugs and I was scared, and it wasn't so much that I—I did have a drug problem, but I had a problem with self esteem, about: How can I go back? Who is going to teach me how to go back and live without using drugs? It took some time for me to get in my head that I couldn't go around those same people, places, and family members that I had been around for so long.

Mr. WAXMAN. Who paid for your care?

Ms. HOWELL. I have no idea. It was provided by Nexus.

Mr. WAXMAN. Ms. Crowell, who paid for her care?

Ms. CROWELL. All of our clients are screened for income eligibility, and if they are at or below one and a half times the poverty level, they do not pay themselves. The State of Texas, the Texas Commission on Alcohol and Drug Abuse, is where most of our funding comes from, and it comes to them from the Federal block grant.

Mr. WAXMAN. Ms. Crowell, Nexus appears to be a remarkable program. Is it typical of a community-based treatment program generally available to pregnant women or women with children?

Ms. CROWELL. There aren't many programs, community-based treatment programs, for pregnant women and their children. When our women and children's program was funded, it was the second in the State of Texas, and a brand new program specifically for pregnant women who can admit during their stay and stay with their newborns is 1 of 31 that was funded by CSAT recently. So we may be typical of those that are currently being funded, but there aren't very many of them. So no, I wouldn't say we are typical.

Mr. WAXMAN. And if you had to operate as a 30-day program and continue to provide effective care to women like Ms. Howell, would you be able to do it?

Ms. CROWELL. I don't think so.

Mr. WAXMAN. Now does this mean, Mr. Lundine, that if we do have this benefit under the President's health care proposal, that we are really not designing a program to meet the special long-term care needs of the hard-core addict, and in fact you indicated you are afraid that some of these limitations may even bar access to treatment, so that if we do have what the President is proposing, we have to expect that we will have current levels, maybe even increased levels of Federal and State funding for substance abuse treatment to maintain and maybe even improve what we are doing now?

Mr. LUNDINE. Let me make it clear in trying to meet the 5-minute rule that I know you impose on yourselves as well—I may not have—the benefit provided by the President and Mrs. Clinton in their historic presentation is salutary. If you do that at the expense of programs that you have just heard about, it is not going to address the problems of the chronically addicted.

So if you can maintain the foundation we have now, maybe even build on it for the chronically addicted, and provide a 30-day benefit that would be more applicable to the kind of people that currently have health insurance, and expand that to people who don't have health insurance, then I think it would be a great improvement.

What I think Congress can do is take something the President has proposed that is a little bit better than we have now and improve on it. What I think Congress must do is not cut out what we have now in order to pay for a system that would treat those who are less needy.

Mr. WAXMAN. I think that is an excellent point, and of course what you are saying would not only apply to Congress but to the States, because the States contribute an enormous amount of money, and Ms. Crowell indicated that in her State, Texas is putting in a lot of that money that is going to help people in her program.

Mr. LUNDINE. Absolutely. We put in actually more State-funded resources for treatment than we get in a Federal block grant. So we more than match the Federal contribution.

Mr. WAXMAN. We have a benefit in the President's proposal that will help a lot of people, but when it comes to the hard-core addicts, what I hear all of you saying is that you are fearful that imposing arbitrary limits and copayments on substance abuse treatment might discourage access and retention in treatment.

Mr. LUNDINE. Exactly.

Copayments are a problem. Just imagine yourself an addict, coming in asking for help, and then they want \$10 at the door every time you come in the door. That is a problem. The combining coverage for substance abuse and mental health services is a problem, and the 30 days is a problem.

Mr. WAXMAN. Mr. Kreidler.

Mr. KREIDLER. I'll pass.

Mr. WAXMAN. Mr. Brown.

Mr. SHERROD BROWN. Thank you, Mr. Chairman.

Lieutenant Governor Lundine, let me pursue what you just said. On the copayment, is there any way to do a sliding copayment scale, a sliding scale for copayments?

Mr. LUNDINE. I think so.

Mr. SHERROD BROWN. Obviously, in this case you don't want a copayment. When do copayments kick in? At what income levels? Do we make those decisions? Do States make those decisions? How should we do that?

Mr. LUNDINE. I think Congress could make those decisions. I honestly don't have a recommendation. I can tell you, there are problems that we can't figure out. For example, we have 40,000 people today in methadone treatment. Do they have to make a copayment every day of the year when they come in for methadone treatment? We don't know the answer to that. So there are questions that need to be straightened out.

I have no problem, for people that could afford to pay, to ask for a copayment. What I have a problem with is, the typical person that is served by a program like Nexus or many programs in New York—Phoenix House, for example, the largest drug treatment therapeutic community in the country in California and New York, could not provide those services to the chronically addicted, to the hard-core drug addict if you are going to require a copayment, because they just don't have the money and because they are not motivated.

Mr. SHERROD BROWN. Ms. Howell, and you, Ms. Crowell, understanding the 30-day limit is, as you said, Ms. Crowell, alarmingly low, in light of budgetary limit, there should be some limit. Probably I think this institution will certainly make that decision. Where do we set the limit using, Ms. Howell, your experiences, and Ms. Crowell, your observations and your work with people that are addicted? What is your recommendation there, either of you?

Ms. CROWELL. We have four different residential programs for different populations, and they range from 4 months to a year, and I feel like each is effective. The longest programs are where more children are along with their mothers, because then you are treating a family unit, not an individual, and it is more complicated.

I think I could live with 4 months or 6 months. We could still—we would have to rearrange our program, but we could certainly try to accomplish the same basic things. But the difference between what we are trying to do in 4 months to a year and trying to do it in 30 days would be impossible.

Mr. SHERROD BROWN. Ms. Howell, would you be here today if the limit were 4 months or 6 months?

Ms. HOWELL. No, I wouldn't, because I am that hard-core addict that you talk about, and I have used and abused drugs for more than 18 years, and there is no way that I think in 4 months that I would have been able to learn the things that I have and the skills that have today in order to go back out into society and not use again.

Mr. SHERROD BROWN. What limit would you decide, based on your personal experience and based on your observations of some of your new friends there?

Ms. HOWELL. I was really comfortable with the 12 to 18 months. Thirteen months was still not long enough for me. The program did say 12 months. I had to ask for an additional 1 month in order to just go through the fear of leaving a very safe, secure environment. I am looking at, you know, 12 to 18 months, and for my son, my family, too. My son is my family. He was really scared, too.

Mr. SHERROD BROWN. Do you agree with Ms. Crowell that the length of time necessary for treatment is related to the number of children that a woman has?

Ms. HOWELL. Yes, I believe that.

Mr. SHERROD BROWN. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Brown.

I want to thank each of you for your presentation today. I think it is important for us to have this information as we try to draft the best health care reform we can. Thank you for being with us.

We are going to take a recess now and reconvene in this room at 1:30 to get the rest of the testimony.

[Whereupon, at 12:02 p.m., the subcommittee was recessed to reconvene at 1:30 p.m.]

AFTER RECESS

Mr. WAXMAN. On our third panel we will hear from witnesses about the mental health benefits proposed in the Health Security Act. Mary Jane England represents the Washington Business Group on Health, Frank McArdle is a consultant with Hewitt Associates, an employee benefits consulting firm; Carol Obrochta represents the Federation for Families With Children With Mental Illness and is accompanied by her daughter, Betsy.

William Dalton is Commissioner of the Department of Mental Health, State of Vermont, on behalf of the National Association of State and Mental Health Directors.

We are pleased to welcome you all to our hearing today. Without

objection, your full statements will be in the record in full. What we would like to ask each of you to do is to limit the oral presentation to no more than 5 minutes.

Let's start with Dr. England.

STATEMENTS OF MARY JANE ENGLAND, PRESIDENT, WASHINGTON BUSINESS GROUP ON HEALTH; WILLIAM DALTON, COMMISSIONER, DEPARTMENT OF MENTAL HEALTH, STATE OF VERMONT, ON BEHALF OF NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS; FRANK B. McARDLE, HEWITT ASSOCIATES, ACCOMPANIED BY JACK MAHONEY; AND CAROL OBROCHTA, FEDERATION FOR FAMILIES WITH CHILDREN WITH MENTAL ILLNESS, ACCOMPANIED BY BETSY OBROCHTA

Ms. ENGLAND. Good afternoon. I am Mary Jane England, a psychiatrist and president of the Washington Business Group on Health and director of the Mental Health Services Program for Youth, a national program supported by the Robert Wood Johnson Foundation.

WBGH is a national nonprofit health policy organization that represents 200 of our Nation's largest industries employers.

I would like to share with you this afternoon what large employers and child and adolescent health professionals have learned over the past decade about providing high quality cost-effective mental health and substance abuse care, and our reactions to the mental health benefit in the Health Security Act.

The Clinton administration has set forth the target of equal coverage for mental and physical health care provided by a unified delivery system of both the public and private sector. This system should be accountable and held to measurable outcomes for serving all Americans regardless of health status.

Innovative private and public health sector plans have demonstrated that a system approach to health care delivery produces better outcomes and cost containment than our current fragmented fee-for-service approach. Their experience, along with scientific advances that have vastly improved treatment effectiveness provide hard evidence supporting the growing agreement to end discriminatory practices in the provision of mental health care.

We all know the problem. Thirty million Americans have a diagnosable mental illness and only a third of those people get any care. Similarly, 15 percent of people with substance abuse disorders get treated. One out of three children with a mental health problem actually get treated in this country.

We have a lot of problems in our system. Problems with access, arbitrary restrictions on mental health benefit and the stigma associated with mental health have meant that many people have not got care and particularly we are concerned with children with serious mental and emotional disturbances that don't have adequate access to services.

Not only is this of great cost to all of us, but it is particularly bad when untreated or inappropriately treated mental health problems cost businesses millions of dollars in lost productivity, and for our children and families, lost days at school. The quality of our mental health system has been largely due to a poor benefit design.

We have a lot of experience with the 1980's where poor benefit design by limiting inpatient and outpatient benefits, particularly limiting outpatient with a high co-pay has actually led to an overutilization of inpatient psychiatric hospitals. We know that comprehensive community based systems of care can be effective for our children.

There has been a lot of discussion this morning and at other times about what the \$241 per American that is in the current Clinton plan will buy. We would like to request of you that you ask the National Institute of Mental Health to review this information and come back to us with an analysis of within a cap of \$241 per health plan member, given that it is an \$1,800 premium, what would that actually buy as far as the kind of comprehensive mental health and substance abuse services which you have mentioned earlier today.

I think the historic significance in what President Clinton has put forward is his expressed intent to integrate the health system. For once now we will have one system for all Americans in the mental health area and that is something that I—most of my background is in the public sector, I am now in the private sector, and I have run a number of public sector programs to begin to put aside the differentiation between public and private to a single delivery system.

But that delivery system has to be accountable and accountable for the treatment of everyone, regardless of health status, so that we stop shifting, and that we start cost shifting some of the prices from the public sector onto the private sector.

In fact, in the public sector, we have a lot of experience in the Medicaid system, which has demonstrated that prescribing limited services is a flawed approach, because it doesn't control costs. Under Medicaid, States have used the rehabilitation option and their authority to define services to broaden the scope of care, and using coordinated care and prepayment methods, we have supported special systems of care for high-need populations, and my colleague will address that more later.

Rather than prescribing limits on individual services, innovative purchasers and providers are forming relationships by which the health plan furnishes a full continuum of services by a panel of multi-disciplinary providers. There needs to be some basic principles for reform and what I would suggest is that we do have model programs out there now that meet the needs of what Americans need.

We have them both in the private sector, in large employers, which you heard mentioned this morning, Federal Express and other large employers that have been able to develop very cost-effective quality programs. Many of these programs have a full continuum of services, treatment is based on individual need, employee satisfaction, and the children, in addition to the private sector efforts, we have had Federal, State and private foundation funding dedicated to reforms for children, and those community-based services have had very positive outcomes. Costs are reduced, children grow up in their families, fewer children are served in long-term care, we see improvement in school attendance and school performance, and there is a decrease in detention days.

I want to thank you for giving us this time to show that experience demonstrates the establishment of limits for mental health care undermines our ability to provide what is necessary and appropriate.

Mr. WAXMAN. Thank you very much, Dr. England.

[Testimony resumes on p. 246.]

[The prepared statement of Ms. England follows:]

STATEMENT OF THE WASHINGTON BUSINESS GROUP ON HEALTH

Mr. Chairman and Members of the Subcommittee:

Good morning. I am Mary Jane England, President of the Washington Business Group on Health (WBGH) and Director of the Mental Health Services Program for Youth, a national program supported by the Robert Wood Johnson Foundation. WBGH is a national non-profit health policy organization of 200 of our nation's largest employers representing all sectors of American industry. Since 1974, WBGH has been involved in efforts to improve health care delivery and financing.

This morning, I would like to share with you what large employers and child and adolescent health professionals have learned over the past decade about providing high quality cost-effective mental health and substance abuse care, and our reactions to the mental health benefit in the Health Security Act in light of those experiences.

The Clinton Administration has set forth the target of equal coverage for mental and physical health care provided by a unified delivery system that is accountable for serving all Americans regardless of health status. That target is a significant departure from the uneven quality and limited access indicative of the public and private systems that operate today. Its achievement will require that we build on innovations already incorporated into private and public plans.

At issue is the *restructuring of health care delivery* so that providers form systems of care that integrate accountability for supplying services and managing financial risk, and purchasers choose the most efficiently managed systems. Innovative private and public health plans demonstrate that a *systems* approach to health care delivery produces better outcomes and cost-containment than the fragmented fee-for-service approach. Their experiences, along with scientific advances that have vastly improved treatment effectiveness, provide hard evidence supporting the growing agreement to end discriminatory practices in the provision of mental health services.

Throughout my statement I will refer to mental health as including care for both mental and substance abuse disorders. While some health plans make distinctions in coverage between these two categories of illness, in practice, the distinction results in diagnosis gaming, fragmentation in the delivery of care and higher associated costs. Our reform efforts must recognize the broad extent of comorbidity among mental and substance abuse disorders and design a system that treats them in an appropriate and cost-effective manner.

I. The Need for Fundamental Change in the Financing and Delivery of Mental Health Services

The financing and delivery of mental health services are in need of fundamental reform. Currently, 30 million Americans have a diagnosable mental disorder, but fewer than one third receive appropriate treatment. Similarly, it is estimated that only 15 percent of people with

substance abuse disorders receive treatment. Many of these disorders are severe, chronic, and recurrent. However, most can be managed effectively and many can be prevented if identified early and treated appropriately.

I would like to describe some of the problems that exist in our current health care system regarding the delivery of mental health services:

A. Access

The first of these problems is access to care. Arbitrary restrictions on mental health coverage and the stigma associated with mental and substance abuse disorders have resulted in access problems that impact the quality and cost of the care that is delivered. Most individuals with a diagnosable mental disorder do not seek treatment; those who do so usually wait until the illness is seriously disabling and more costly to treat. What's more, most children with serious mental and emotional problems do not have adequate access to services. Prevention and early intervention services are rare in our education, juvenile justice, and foster care systems; again, delaying availability of services until the problem is serious and disabling.

Employers pay for mental health and substance abuse disorders whether they include coverage in their health plans or not. Untreated or inappropriately treated mental health problems cost business millions of dollars in lost productivity, accidents, overuse of medical care, and disability. Time and time again we see that the failure to access early and appropriate care drives up spending both for the direct and the indirect costs of these illnesses.

B. Quality

The second problem in our current system that I would like to address is quality. First, hospitalization, the most restrictive and costly treatment setting, is unnecessarily overutilized. The problem, in part, is due to poor benefit design. Private insurance commonly reimburses more generously for inpatient services, thereby creating a financial incentive to use hospitalization. Originally designed as a way to protect the most seriously ill individuals, the discrepancy in coverage between inpatient and outpatient care discourages early intervention with less costly treatments.

Explosive growth in provider supply is another factor in the inappropriate use of hospitalization. Between 1984 and 1990, the number of free-standing psychiatric hospitals increased by 84 percent. The beds were filled by sophisticated marketing campaigns targeting adolescents and substance abusers. The result was alarming increases in employer expenditures and a large amount of unjustified and even harmful care.

In addition to the overuse of hospitalization, the provision of good quality care is compromised by a shortage of alternative treatment settings. Many plans still reimburse for inpatient or outpatient care only. Instead, the provision of a full continuum of care in a variety of treatment settings should be encouraged. Comprehensive community-based systems of care

result in improved outcomes and cost effectiveness.

Finally, the provision of good quality care is compromised by poor recognition and treatment of mental and substance abuse disorders in primary care. For example, a 1989 RAND Corporation study found that primary care physicians detected depression in only 51 percent of patients with a current depressive disorder in fee-for-service care. Only 42 percent of the cases were detected in pre-paid settings. But, training in recognition and treatment for primary care physicians alone will not rectify the problem. System-based incentives are needed to improve the link between primary care and mental health providers, increasing the involvement of primary care physicians in the diagnosis, referral, and management of mental disorders.

C. Cost

The final issue I would like to address is cost. During the 1980s, mental health was one of the fastest growing segments of the expanding cost of providing health benefits. Between 1986 and 1990, employers saw their costs for mental health services increase by an average of 50 percent, with 65-70 percent of the spending on inpatient care. The most generous fee-for-service plans were those that experienced the most dramatic cost increases.

In the face of rising and unmanageable costs, most employers began to restrict their mental health benefits. Common restrictions included caps on annual and lifetime dollars and days, along with greater cost sharing by beneficiaries. Such restrictions leave the most seriously ill without adequate protection, as many of those patients are diverted from private sector care into the overburdened public sector. Restrictions also mean that many Americans cannot afford the cost of adequate mental health care and wait to seek treatment until the illness is serious and disabling. Restrictions often prove futile for purchasers as well, as employers report consequences such as diagnosis gaming, overuse of medical care, and higher disability costs.

Of importance to the current debate is the use of fee-for-service data from the 1980s to project the cost of mental health benefits under health care reform. The approach amounts to comparing apples and oranges. It does not account for the systemic changes in care delivery that have enabled large purchasers to eliminate limits on mental health coverage. The elimination of limits encourages treatment based on medical necessity and appropriateness rather than on benefit coverage, correcting the inefficiencies in service delivery driven by poor benefit design. More accurate cost projections can be made by examining the data of managed systems of care in the public and private sectors.

I ask that the Committee consider having the National Institute of Mental Health review the Health Care Financing Administration cost projections and provide an analysis of what services can be provided within the cap of \$241 per health plan member in the \$1800 premium cost per year projected for the Health Security Act.

II. President Clinton's Health Security Act

I want to commend the President for his leadership on health care. His plan signals three fundamental tenets in the health care debate. First, universal access regardless of ability to pay or medical history must be achieved. Second, reform efforts that focus solely on financing access to care in the absence of correcting inefficiencies in the delivery system will not succeed. Finally, equity for mental and physical health care is essential.

Of historic significance is the expressed intent to integrate the public and private mental health systems. Use of a single delivery system that is accountable for the treatment of everyone regardless of health status will stop the shifting of the most seriously ill patients from the private system to the public system and the shifting of uncompensated costs from the public system to the private system.

Our current structure is a two-tier system. The private system primarily serves the insured with hospitalization and office-based therapy. The public system primarily serves the uninsured, poor, and severely ill, and is characterized by a continuum of community-based programs aiding individuals and families least able to afford medical and support services.

As we move forward, there is something to be learned from each of those systems. The public sector has shown itself to be adept at defining comprehensive systems of care for chronically ill individuals, while the private sector has introduced value-based purchasing to health care and has become quite skilled at shopping for quality as well as cost. In integrating the systems, questions will abound about *how* to wrap in state dollars from *which* categorical agencies to fund *what* services. Our efforts to answer those questions will be guided by new definitions of quality and value. Integral to our solutions will be lessons learned from successes in both the private and public sectors.

The mental health benefit in President Clinton's Health Security Act is a respectable step to ending discrimination in the provision of mental health services because of the elimination of lifetime limits for mental health care. Nevertheless, the proposal poses a risk to the innovative reforms in cost-effective mental health service delivery already underway. The risk is embodied in the prescribed annual limits on individual services. The practice of prescribing limits perpetuates the false distinctions between mental and other medical illnesses. More important, the experience of private insurance demonstrates that a prescribed benefit dictates the type of care provided. Much of the care delivered under this approach is inappropriate, excessively costly, and may even be detrimental to the patient.

In the public sector, experience in the medicaid system demonstrates that prescribing limited services is a flawed approach because it does not control costs. Under medicaid, states have used the rehabilitation option and their authority to define services to broaden the scope of care provided and allow the flexibility necessary to appropriately care for poor, disadvantaged, and disabled individuals. Using coordinated care and pre-payment methods, they also support special systems of care for high need populations. Under those arrangements, the organized

system of care shares risk and provides a full continuum of services.

Rather than prescribe limits on individual services, innovative purchasers and providers are forming relationships by which the health plan furnishes a full continuum of services by a panel of multi-disciplinary providers and both assumes financial risk and is accountable for the outcomes of care. As a result, the most appropriate and least costly level of care is selected based on individual need from determinations of medical necessity, severity of illness, level of functioning, and patient satisfaction. Defined limits on particular services are unnecessary. This systems approach is especially effective for chronic and recurrent conditions such as mental health and substance abuse disorders, which require varying intensities of care over time.

III. Basic Principles for Reform

Most mental and substance abuse disorders can be prevented or managed effectively if identified early and treated appropriately. In fact, routine early identification with appropriate treatment may dramatically reduce the use of medical services. In contrast, undiagnosed and untreated, these disorders often prove seriously disabling, life threatening, and costly to individuals, families, and society.

The Washington Business Group on Health supports reform of the U.S. health care system that includes universal access to a full continuum of medically necessary and appropriate mental health and substance abuse services delivered through an organized system of care. A managed approach to service delivery is critical to providing a full continuum of services in a way that flexibly meets individual need and is affordable to the health system. The establishment of limits with respect to mental health and substance abuse that do not apply with respect to other illnesses should be prohibited.

I encourage the Committee to consider that the best possible public policy is to provide for this category of diseases as we would for any other medical illness. If we are to achieve affordable quality health care for all Americans, we must reform our health care system so that all health problems are effectively treated. Mental health and substance abuse problems are no exception. They are prevalent in every aspect of our society, including our workforce. Experience in private sector health plans demonstrates that limiting the benefit for mental health and substance abuse services undermines efforts at cost-containment and quality improvement.

IV. Delivery System Reform: Organized Systems of Care

Our use of the term "organized systems of care" is comparable to that of the "accountable health plans" discussed in current reform proposals. The concept is one of a unified and accountable health care delivery system that serves all Americans and replaces the fragmented systems that operate today. Mental health services are mainstreamed into the system and incentives are provided to health plans so that even those individuals with the most severe

illnesses receive treatment from the system.

A. Definition

Organized systems of care (OSCs) are integrated financing and delivery systems that use a multidisciplinary panel of providers selected on the basis of quality and cost management criteria to furnish comprehensive services. The systems incorporate incentives to provide only appropriate and necessary care into their operations and are accountable to patients and purchasers on the basis of quality, cost, and outcomes information.

Using one system that both provides care and assumes financial risk ensures efficiency and coordination of care delivery. This is especially important for mental health and substance abuse disorders, which are often chronic or recurrent and can be effectively treated by providers from more than one discipline.

B. System Characteristics

A Full Continuum of Services. OSCs provide a full continuum of services, including preventive, primary, acute, rehabilitative, and chronic care. Those individuals who need intensive care are able to obtain it, while the movement of individuals to less intensive levels of care is encouraged. In a well managed system, arbitrary benefit limits defined by numbers of inpatient days and outpatient visits are unnecessary. Treatment is based on individual need from determinations of medical necessity, severity of illness, level of functioning, and patient input.

Prevention and Early Intervention. OSCs encourage prevention and early intervention through educational efforts, financial incentives to seek care early, and good communication between primary care and mental health care providers. A resource referral mechanism directs patients to the most appropriate level of care in the delivery system.

Accountability. The system of care is held accountable to patients and purchasers on the basis of quality, cost management, and outcomes information. Such measures as patient satisfaction and population health status are used to ensure that providers furnish appropriate, high quality, and cost-effective care. Treatment effectiveness is evaluated in terms of functional as well as clinical outcomes, with emphasis placed on how treatment impacts the individual's daily life.

Continuous Quality Improvement. OSCs incorporate the principles of continuous quality improvement (CQI). Basic characteristics of CQI include that the quality of care must be based on an understanding of the needs and expectations of the "customers," the specification and improvement of the product or service must be continuous and measurable, and everyone in the system must be involved in improvement because everything can be improved. By definition, these principles prescribe that the system of care will differ from community to community based on the characteristics of that community.

Information Management. OSCs provide for the collection and dissemination of relevant data. Good decision-making depends on what we know about utilization, quality, and cost. Information can be collected to improve the performance of the system, facilitate choices about care, and ensure accountability to patients and purchasers.

C. Organized Systems of Care in Relation to Current Managed Care Efforts

Organized systems of care expand on the best practices of our current health maintenance organizations and managed mental health programs to effect a fundamental change in the way that health care is delivered. Current managed care efforts are an important improvement upon traditional fee-for-service arrangements which incorporate no cost or quality controls. But, as currently practiced, much managed care is oriented toward procedure- or service-specific utilization review rather than quality improvement mechanisms and accountability for overall performance.

IV. Model Reforms in Mental Health Service Delivery

Whereas the concept and use of OSCs is evolving, several of the nation's largest health care purchasers have ample experience with the model and proven success in maintaining quality while holding down costs. It is important to note, however, that each employer has approached improvements in mental health service delivery somewhat differently. For example, one may contract directly with a system of care, while another will work with the health maintenance organizations serving its employees, and a third may contract with a managed mental health care firm.

Regardless of the approach, features common to all the plans include:

- Care is delivered in a managed environment. Employers have not experienced success in managing the cost of providing mental health and substance abuse care or evaluating the quality of that care in an unmanaged fee-for-service system.
- A full continuum of services is available, from prevention and early intervention to chronic care.
- Treatment is based on individual need from determinations of medical necessity, severity of illness, level of functioning, and patient input.
- An emphasis is placed on employee satisfaction and the ability to evaluate the quality of care delivered.

In using this approach, employers have been able to increase access to care, improve employee satisfaction with the health plan, hold recidivism rates steady, and dramatically reduce

the cost trend for mental health care. In many cases the cost trend for mental health is well below the trend for medical/surgical care. Brief descriptions of three employer health plans indicative of innovative efforts are attached.

In addition to private sector efforts, federal, state, and private foundation funding has been dedicated to reforms in service delivery for families with children and adolescents with serious emotional and mental disorders. Most notably, in 1988 the Robert Wood Johnson Foundation provided \$20 million in grants through the Mental Health Services Program for Youth to eight states to encourage the development of service systems for children and their families. The communities are located in California, Kentucky, North Carolina, Ohio, Oregon, Pennsylvania, Vermont, and Wisconsin. It is the single greatest financial commitment to the child mental health systems of care concept to date, although other private foundations, such as the Annie E. Casey Foundation and the Pew Charitable Trust have recently joined the effort.

These community-based systems of care are getting positive results in a number of areas:

- Costs are reduced by serving children with an array of community-based services.
- More children are growing up in their families, marking a significant shift to in-home or home-like care settings.
- Fewer children are served in long-term institutional, residential, or out-of-state settings.
- Gains are seen in improved school attendance and school performance.
- Youth correction systems see a decrease in detention days.

V. Conclusion

The Washington Business Group on Health and its members appreciate the attention of this Committee on the provision of equitable coverage for mental health and substance abuse care in health care reform through the restructuring of the health care delivery system. Experience demonstrates that the establishment of limits for mental health care undermines our ability to provide medically necessary and appropriate care at an affordable cost. I offer the help of WBGH as you work through this serious public policy concern.

Mr. Chairman, this concludes my prepared statement. I appreciate the opportunity to appear before the Committee, and would be pleased to answer any questions you or the Committee members may have.

Employer Case Studies

A. Honeywell, Inc.

Honeywell has approximately 12,000 domestic employees enrolled in organized mental health systems. The first system of care was developed in 1990 in Albuquerque, New Mexico, serving 2500 employees.

In 1990, employees in Albuquerque had the option of choosing between two HMOs (in which 70 percent of employees enrolled) and fee-for-service care (30 percent of employees enrolled). The benefits in the HMOs were unsatisfactory to employees, and Honeywell was forced to consider restricting benefits in the FFS plan to control the rapidly escalating costs for adolescent mental health care.

In 1991, rather than restricting benefits, Honeywell carved out the mental health program. They selected a single specialty psychiatric and chemical dependency group practice to provide all mental health services. Benefits were improved by expanding the scope of services, lowering the co-pay, and eliminating maximum caps. The out-of-network option was eliminated so that all care must be obtained through this system of care.

The goals in selecting the group practice were to have: 1) integration of all care under one management structure, with standards of care and excellent care management; 2) demonstrated ability to treat adolescents and their families with minimum use of higher cost hospitalization yet with better outcomes; 3) increased focus on prevention and early intervention through worksite prevention activities; 4) improved diagnosis and care management; and 5) a commitment from the system of care to continuous quality improvement through a partnership where Honeywell is bringing CQI trainers to assist with quality efforts.

The group practice is responsible for creating a system of care that offers a full continuum of services delivered by a multidisciplinary panel. The system uses salaried providers so that there is no incentive to over- or under-treat. In addition, the system contains a strong prevention focus, with an employee assistance program to provide early and easy access to services, and integration with occupational programs such as health promotion, prevention, drug testing, disability management, and management training.

There is no benefit design with the exception of a lifetime limit of two treatments for substance abuse. The system of care determines the most appropriate care and develops a treatment plan. Multidisciplinary evaluation, treatment, and follow-up are available as appropriate. Although a treatment plan may include diverse levels and modes of care over time, one member of the care team is responsible for tracking the patient through various treatment settings. The patient and family are fully informed so that the care plan is known to everyone.

The advantages to both Honeywell and the provider organization include: 1) the ability to deliver the highest level of appropriate care rather than treatment controlled by benefit design;

2) cost containment through quality and variation control versus denial of care or discounted fees; and 3) an ongoing relationship that allows for the development of a common language and purpose, consistent messages to beneficiaries, and shared feedback to continually improve the system.

The outcome has been extremely positive with high employee and dependent satisfaction, cost reductions of 40 percent in the first year and cost increases held to 4 percent in subsequent years.

B. Digital Equipment Corporation

Another innovative effort is underway at Digital Equipment Corporation. Digital has committed itself to working with its HMOs to improve the provision of care. To that end, HMO standards have been developed, including standards for data, financial stability, quality, access, and mental health and substance abuse care.

Regarding mental health and substance abuse services, some common problems identified by Digital and their HMOs include rigid adherence to benefit limits; lack of case management; barriers to initial access; lack of specialty staff; and lack of documentation of value received by patients. Expectations for improvements in these areas have been outlined, with an underlying focus on increasing flexibility in meeting the needs of individual patients and to inform the health care delivery process with data.

For example, a triage mechanism improves access to the most appropriate level of care in the system. An individualized treatment approach is encouraged with decisions based on determinations of medical necessity and measurement of patient functioning and well-being. Case management is recommended for all inpatient or alternative treatment facility admissions to ensure an appropriate post-discharge regimen and follow-up care.

One of the most exciting initiatives involves an intensive evaluation of treatment for depression with three HMOs offered to Digital employees: the Fallon Community Health Plan, the Harvard Community Health Plan, and the Matthew Thornton Health Plan. The group will use a version of the outcomes module for major depression and dysthymia, an assessment tool developed by a team of clinicians led by G. Richard Smith at the University of Arkansas. Presently, a pilot study is underway to evaluate and refine the assessment tools.

The objective of the effort is to collect and share data on the quality of care with the intent of using the information to improve care across all three organizations. Information learned will also be shared with other providers and purchasers in order to promote widespread improvements in the management of depression in a variety of managed care settings.

C. Federal Express

Federal Express mental health and substance abuse benefit costs were higher in

comparison to similar companies and were rising at an average of 16 percent per year from 1986 to 1989.

Their analysis revealed that they were experiencing an increase in the unit price of mental health services as well as an increase in hospital admissions and inpatient length of stay. The absence of price and utilization controls in the health plan contributed to cost increases as mental health providers sought to recover from Federal Express the revenues lost due to control mechanisms in place in other company plans. Additionally, the Federal Express health plan offered greater benefits for inpatient care and limited benefits for outpatient care, driving employees to the more expensive level of care.

In spite of the increased cost, impact analysis revealed decreasing value of mental health services received by employees and their families. Many individuals were reaching the maximum benefit level without significant improvement in mental health status.

After reviewing proposals and conducting site visits, Federal Express selected a specialized behavioral services vendor to manage mental health utilization and pricing. They also amended their health plan to remove the barriers to outpatient services and include day treatment and residential treatment, thus offering a full continuum of mental health services.

Federal Express saved more than \$18 million in the first three years of the managed care program. Savings were measured independently by claims paid data in their MED-STAT claims data base. Employee satisfaction has risen from 85 percent at the onset of the program to its current level of 91 percent. Recidivism has remained constant since implementing the plan.

Mr. WAXMAN. Mr. Dalton?

STATEMENT OF WILLIAM DALTON

Mr. DALTON. Thank you, Mr. Chairman. Mr. Chairman and members of the committee, my name is Bill Dalton and I am here on behalf of the State mental health commissioners and directors association, NASMHPD. I also represent that entity on an advisory board for the Center of Mental Health Populations, which not only deals with adults and children suffering from a major mental illness or severe emotional disturbance, but vulnerable elderly populations as well.

I do want to address that population in its relation to the Clinton plan.

This is a complicated and somewhat scary road I think for all of us that we are traveling right now, but it is, as Dr. England said, with a great deal of relief and I think gratitude that we have embarked upon this endeavor.

So the first very strong message from NASMHPD and from myself personally is that it is about time, and the quicker we can get on with it and address some of the difficult internal issues, the better off we will be on behalf of serving these vulnerable populations.

Just very preliminarily, in addition to the information that I submitted, I thought it might be appropriate to make sure that all of us dealt with three or four principles that I think are very, very important in all of this, and I think then you will see how they connect with the benefits plan and stuff like that.

The first principle, and these have been adopted in Vermont by an advisory group for mental health and substance abuse, is that there should be no discrimination in services at all across the arena of health care reform. What that means is that people, regardless of age, background, economic capacity, or label or degree of disability, ought to have the appropriate array of services necessary to them, that there should be equity in this process, cost containment, managing costs into the future, identifying what are appropriate services and hoping that they are cost-effective will have to go hand in hand with, for example, the triaging of a system when there is simply not going to be enough money, particularly to start with, to go around.

I think over time that can change, but we certainly are not going to start from that point. We are going to have to build something into the future. But equity means that if you suffer from an acute or chronic condition of substance abuse or mental health needs, mental illness, that you should be treated as fairly as someone with a regular health benefit.

That consumers should have choice, that we should have a system that will clearly give them some opportunities. We will not be able to fund every kind of a service, but we should have choices for people in determining what is the most appropriate service for them, and it should be driven by the consumers, that it should be comprehensive. The comprehensiveness is very important and it is probably the primary reason why substance abuse and mental health services need to attain parity with regular health care benefits.

I think that picking up on the theme of ensuring that we have proper data that shows what the outcomes are, that the providers of mental health and substance abuse services will be very quickly very capable of showing the impact, not only in terms of improved mental health of individuals, but improved general health of individuals, if the right array of services are available in this arena.

So with those four basic principles, I would ask you to consider them as you take a look at this plan or any other plan, or as you consider modifying that plan. I think that there are ways of making it cost-effective without abridging these principles. I think it will take a lot of hard work, but I really believe that it can be done.

The association, NASMHPD, believes that it can be done, and I think that, as Dr. England has said, there are ways of proving that it can be done.

Let me emphasize that if nothing else, we must have a strong database that will take us into the future. If we don't begin to identify and work towards changing systems that are not efficacious, this is not just mental health, not just substance abuse, this is throughout the whole delivery system, that we won't gain much ground.

We really have to know that what we are doing works. If there is nothing else that comes out of Federal legislation, I would strongly urge you to hold all of us accountable for what it is that we are putting in place in terms of these systems.

I think that is a—I just can't emphasize how strongly that had message should be taken.

My second basic message is that this system absolutely must be driven by consumers, and health care, mental health care, substance abuse care in the past has simply not done—that has not occurred. So that we need to pay very close attention and give more time to the folks at the other end of this table today.

I think that when I talk about consumers, I mean people who are receiving services, family members, the communities of people who are receiving these services, if we really believe in sort of a family preservation approach to where life is going to go, then we need to include all of these people in the decision-making process, and not leave it simply to the professionals. Again, I think that is something that you can very easily in effect mandate.

I will leave it at that. A parting comment would be that the President did say that this was a Health Security Act in terms of the low income populations, the most disabled populations, that security must be afforded in some fashion, and we can talk about the benefits.

Mr. WAXMAN. Thank you very much.

[The prepared statement of Mr. Dalton follows:]

STATEMENT OF WILLIAM DALTON

The National Association of State Mental Health Program Directors welcomes the opportunity to offer reactions to the President's "Health Security Act" as it may potentially impact public mental health systems.

Financial Role of State Mental Health Agencies

In fiscal year 1990 the 50 state mental health systems expended \$12.2 billion. Of this \$12.2 billion, 57% was devoted to inpatient psychiatric treatment (\$7.0 billion) and 38% was devoted to community mental health services (\$4.6 billion). Each year the composition of state mental health spending changes away from inpatient services and towards community services.

Of this FY 1990 \$12.2 billion, \$9.83 billion was derived from state general revenue (including \$610.365 million in state match for Medicaid) and \$1.031 billion was derived from federal Medicaid (8.45% of the \$12.2 billion). Additionally, in FY 1990, \$3.1 billion in Medicaid payments, not directly "controlled" by the state mental health agency (SMHA) was "channeled" through the SMHA to community programs. Medicaid and state general revenue are the two most significant revenue sources of public mental health programs.

The \$12.2 billion in SMHA expenditures is slightly less than 50% of all public mental health expenditures in the nation (including Medicaid, VA, Medicare, and county and other local government expenditures). The public mental health expenditure of \$28.0 billion compares with a total direct national mental health services expenditure (in FY 1991) of \$68 billion (or 41.18%).

In FY 1988, 4.7 million persons with mental illnesses were served in the 50 state mental health agencies funded or operated mental health organizations.

SMHAs and the Clinton Plan

NASMHPD endorses the Clinton proposed goals of:

- (1) universal access to health insurance;
- (2) a prohibition on lifetime limits on benefits;
- (3) a prohibition on exclusions based on pre-existing conditions;
- (4) a guarantee of portability of insurance coverage;
- (5) the use of community ratings which no longer permit experience ratings; and
- (6) creation of a standardized benefits package which includes a mental health benefit.

NASMHPD further endorses:

- (7) The full integration of persons on Medicaid into the purchasing alliances/AHP reform structure;
- (8) Complete parity between mental health and physical health benefit coverage; and

- (9) The goal of the integration between the public and private mental health specialty sectors which recognizes flexible and varied approaches consistent with state circumstances;
- (10) Continuation of all current law Medicaid long term options for anyone currently eligible for Medicaid and creation of the proposed new long term care option which allows much state flexibility; and
- (11) Creation of the proposed new 100% federally funded children's program.

National health care reform will impact each state, financially and socially, in different ways. We encourage the Congress to be sensitive to these state-by-state variations. Among the factors which will determine the impact of national health care reform on the states are:

- (12) The state's current state initiated health care reform situation;
- (13) The state's current state initiated public mental health reform situation;
- (14) The private sector managed mental health experience;
- (15) The state's currently insured and uninsured situation;
- (16) The scope of any state mandated mental health insurance coverage;
- (17) The state's use of the Medicaid options allowed in current law; and
- (18) The state's HCFA waiver situation promoting Medicaid reform.

NASMHPD's problems and concerns with the Clinton proposed "Health Security Act" include:

- (19) The proposed mental health benefit not only rejects the principle of parity with physical health but is an unrealistically limited benefit which will not well serve persons with any serious mental illness;
- (20) The more modest the standardized mental health benefit, the more unlikely public-private sector integration will occur. The more modest the mental health benefit, the greater the burden placed on the state system;
- (21) The proposed coinsurance obligations (deductible and copayment) are totally unrealistic for modest income individuals and will result in reduced access to medically necessary mental health services;
- (22) The failure to count many of these coinsurance obligations toward the out-of-pocket limit, will further result in reduced access to medically necessary mental health services;
- (23) The provision whereby the non-cash (non-SSI, non-AFDC) Medicaid population no longer receives the acute care benefit offered through Medicaid in Medicaid generous states, combined with the new coinsurance obligations which such persons do not currently incur under Medicaid, will result in a reduction of medically necessary mental health services in some states;
- (24) The combination of these modest benefits, extraordinary coinsurance obligations, and reductions in Medicaid coverage for the non-cash population will have an especially negative impact on some children with serious emotional disturbance;
- (25) States are concerned with the short term financial instability and chaos resulting from the proposed elimination of the Medicaid disproportionate share hospital program; and

- (26) The revised definition of Medicaid "long term care services" (Section 4221 (c)) does not include the existing authority for Medicaid institutions for mental diseases (IMDs) for persons under the age of 22 years and over the age of 64 years. In FY 1991, 44 states expended \$1.114 billion in Medicaid IMD services for persons over the age of 64 years and 39 states expended \$895.803 million in Medicaid IMD services for persons under the age of 22 years. Thus, persons with serious mental illness, and the states serving them would lose \$2.000 billion in IMD payments.

- Technical Correction: This \$2 million loss could be averted by amending Section 4221 (c) by including in the definition of Medicaid long term care services, IMDs as authorized in current law section 1905(a)(14) and (16).

The proposed integration of the public and private specialty mental health systems has been substantially undermined by a very modest and inadequate mental health benefit. The integration has been further undermined by a failure to authorize funds for the proposed "pilot program" (section 3521), failure to specifically authorize more flexible uses of Medicaid for purposes of achieving integration, and for failure to specifically authorize state government's ability to govern alliances and AHPs in regards to the management of the mental health benefit.

Health Care Reform and Mental Health Reform in Vermont

Attached is the Vermont health care reform standardized benefit, with parity for mental health, offered to all Vermonters.

Handed-out at the hearing will be detailed documents on the Vermont Health Care Authority's accomplishments to date and the Vermont Health Care Authority's long term care proposal. Mr. Dalton will discuss the linkages and relationships between acute health care reform and long term care reform.

VERMONT HEALTH CARE BENEFIT

BENEFIT/SERVICE	ISC "IN-NETWORK" PLANS — COVERED SERVICES AND COST SHARING	ISC POINT-OF-SERVICE PLAN — COVERED SERVICES AND COST SHARING	*OPEN* SYSTEM — COVERED SERVICES AND COST SHARING*
DEDUCTIBLES	None for services provided within the ISC	Single \$200 2-person \$350 3 +: \$500 per year	Same as point-of-service plan
COINSURANCE	None for services provided within the ISC	30% of costs for covered services for hospitalization and specialty care	20% of costs for covered services for hospitalization and specialty care
OUT-OF-POCKET MAXIMUM	Single: \$1500 Family: \$3000	Same as ISC (for covered services)	Same as ISC (for covered services)
HOSPITAL Inpatient (semiprivate) Intensive care Operating room Auxiliary	100% covered	After deductible, plan pays 70% of hospital costs, patient pays remainder	After deductible, plan pays 80% of hospital costs, patient pays remainder
MEDICAL In-hospital Surgical Outpatient surgical Lab & X-ray Primary & preventive care (see note 1 at end of benefit plan summary) Specialty care and major oral surgery OB/GYN specialty care Periodic OB/GYN exam	100% covered 100% covered \$5 copayment per visit \$5 copayment per visit No copayment for preventive services; \$5 copayment on others \$5 copayment per visit with referral from primary care provider (PCP) \$5 copayment per visit Women may self-refer to ISC-participating OB/GYN with no copayment	After deductible, plan pays 70% of fee schedule for medical service; patient pays remainder. Deductible and coinsurance are waived for preventive services, including periodic OB/GYN exam	After deductible, plan pays 80% of fee schedule for medical services; patient pays remainder. Deductible and coinsurance are waived on preventive services, including periodic OB/GYN exam.

OTHER Ambulance Physical, occupational, speech and nutrition therapy to restore functional capacity or minimize limitations Hospice Home Care Skilled nursing facility (subacute care) Chiropractic	100% covered (no coverage for transport) \$5 copayment per visit with referral from PCP	After deductible, plan pays 70% of approved charges for covered services	After deductible, plan pays 80% of approved charges for covered services
	100% covered	After deductible, plan pays 70% of fee schedule for speech, occupational, nutrition and physical therapy, hospice, home care, skilled nursing facility services, chiropractic, vision, hearing services and medical supplies	After deductible, plan pays 80% of fee schedule for speech, occupational, nutrition and physical therapy, hospice, home care, skilled nursing facility services, chiropractic, vision, hearing and medical supplies
	100% covered		
	100% covered up to 100 days		
	\$5 copayment per visit (see note 2 at end of benefit plan summary)		
OTHER (continued) Vision and hearing care	\$5 copayment, vision exam once every 24 months, routine hearing exams		
Medical supplies and nutrition supplements (case by case basis if essential to avoid more costly care)	100% covered if need established		
DURABLE MEDICAL EQUIPMENT (see note 3 at end of benefit plan summary)	\$100 deductible per person, 20% of rental charges or cost, which ever is less (cost sharing waived for low-income persons)	After deductible, plan pays 70% of cost or rental charge, whichever is less	After deductible, plan pays 80%
MENTAL HEALTH Inpatient services	Inpatient general and psychiatric hospital coverage: same as other types of admissions	After deductible, plan pays 70% of fee schedule for mental health services	After deductible, plan pays 80% of fee schedule for mental health services
Outpatient services	\$5 copayment per visit, including intensive intermediate care services		
ALCOHOL AND SUBSTANCE ABUSE Inpatient services	100% covered for inpatient residential and detoxification services	After deductible, plan pays 70% of fee schedule for substance abuse services	After deductible, plan pays 80% of fee schedule for substance abuse services
Outpatient services	\$5 copayment per visit, including intensive intermediate care services		
PRESCRIPTION DRUGS (see note 3 at end of benefit plan summary)	25% coinsurance per script or refill; annual out-of-pocket maximum of \$200 single, \$350 for 2P and \$530 for 3P + if generic available and brand chosen, plan pays 80% of generic cost. 20% applied to out-of-pocket maximum. Coinsurance waived for low-income persons.	After deductible, plan pays 70% of fee schedule of payment for drugs	After deductible, plan pays 80% of fee schedule for drugs

EMERGENCY ROOM (see note 4 at end of benefit plan summary)	For life-threatening and urgent emergencies: \$5 co-payment, PCP should be contacted within 24 hours of event For non-life-threatening and non-urgent emergencies: with authorization from PCP, \$5 co-payment; without authorization from PCP, \$50 co-payment Co-payment waived if admitted to hospital	After deductible, plan pays 70% of fee schedule for covered services	After deductible, plan pays 80% of fee schedule for covered services
DENTAL	Persons may use dentists of their choice; \$5 copayment per visit; comprehensive dental services for children through age 17, including preventative dental care and screening, restorative services, annual exam and cleaning, and limited corrective services. Emergency services only for adults for control of pain or infection.	cost sharing the same as ISC "in-network" plan.	After deductible, plan pays 80% of fee schedule for covered services (for same services covered by ISC)

*See the discussion at the end of the benefit description on service limitations and utilization control in this plan.

*See description at end of benefit plan summary for cost sharing required and limitations on services provided outside the ISC.

*See discussion at end of the benefit description on service limitation and utilization control in the open system

Mr. WAXMAN. Mr. McCardle.

STATEMENT OF FRANK B. McARDLE

Mr. McARDLE. Mr. Chairman, members of the committee, my name is Frank McArdle. I am a consultant with Hewitt Association and I manage Hewitt Research functions here in Washington D.C. I am accompanied by Jack Mahoney, a physician with a background in psychiatry, addiction medicine and public health, and Jack has been very active in the design of the managed mental health programs that we will talk about during our testimony.

What we would like to do this afternoon is really cover two things, give you our preliminary reactions to the design of the Health Security Act, but also to illustrate for you what we think is the most important principle, which is that the cost of this plan is going to vary very dramatically with the particular design.

We use a database that has 8 million lives in it, it has very recent data in it for 1991, and it captures the more recent information that typically is not in the older, historical databases that government actuaries use.

Now, when I use the term managed mental health, I recognize it is a controversial term and it has a lot of different meanings. Sometimes it is used to describe a system that denies care or shifts costs.

We don't design a system that way. We design one that optimizes the needs of the individual by seeing they get the appropriate services in a timely fashion. So a good managed mental health program will provide easy access to care to a qualified person who can direct them to the right treatment resource and then manage that care over a period of time. A state of the art managed mental health program can give you better benefits at lower cost and we will try and illustrate that for you with some numbers.

The degree of savings that can be realized are really quite dramatic. Mary Jane mentioned some employers and there are case studies where savings of 25 percent to 35 percent are not uncommon, and in some situations, even greater savings.

Let me clarify that when I am talking about a managed program, I am not talking about an HMO. An HMO would budget a low, flat fee per enrollee. What we are talking about is using a fee-for-service plan with case management and it has different financial incentives. So it costs more money than a typical HMO would budget, but sometimes it results in better care.

What we have done is taken the President's proposed mental health benefit, and you should have a chart with the oral testimony, that may be easier to follow along with the numbers, and what we have done is priced the benefit in two different ways.

One is we priced it as if it were a totally unmanaged benefit. There you see on the top line that it would cost about \$210 per covered life, or \$164 if it were a fully managed program that were a low cost-sharing option. If we convert those numbers to a cost per single adult, again, you see similar things in chart 2 as a cost per single adult, it would be \$242 for an unmanaged plan versus \$189 for a fully managed low-cost sharing plan.

It appears that our pricing is fairly close to the administration's, although I can't tell you exactly how close because we don't know

what assumptions they have used. Dr. Feder this morning said \$241. Earlier in medicine and health they reported \$256, so we don't know exactly.

But you can see from these numbers in chart 2 that we are in the same ballpark. Where we differ from the administration is in two ways. One, in our model, the share that goes to mental health is smaller than in the administration's. If I understand their numbers correctly, about 13 percent of the total premium would go to mental health in their package.

In our situation, when you get to 13 percent, that is already a problem level. We see 10 percent as a more typical level.

The second thing is, if you look at these charts and go from the top to the bottom, what we see is a much greater potential to save money by using these managed care programs, and what these do is as you are going down this chart, you are having richer benefits without limits, and you can see that you can do that if it is managed properly for a cost that is equal to or less than what the administration seems to be pricing.

So there is good news there in that there is a potential to offer benefits, generous benefits, and if the care is managed, to do so in a cost-effective way.

A good feature of the Health Security Act is that it does cover case management, and that can be very cost-effective. But one problem is that it is a discretionary service, it is not mandatory. If it were mandatory, you would have bigger savings.

Finally, there was a lot of discussion about limits this morning, and we would have more to add if you want to in the questions and answers, but you pointed out, Mr. Chairman, that some Medicaid patients have richer benefits now than they would under the standard package. I would just add that there are many workers now who have richer mental health benefits than they would under the standard package, and under this proposal, if they have to buy through the regional alliance, they would lose those benefits, potentially lose those benefits.

So the news is good in that there is the capability to manage the cost, but the plan has to be designed in a way to capitalize on it.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you very much, Mr. McArdle.

[Testimony resumes on p. 282.]

[The prepared statement of Mr. McArdle follows:]

Statement of

Frank B. McArdle, Ph.D.

John J. Mahoney, M.D., M.P.H.

of

Hewitt Associates

Mr. Chairman and Members of the Committee, my name is Frank McArdle. I am a consultant with Hewitt Associates, and I manage our firm's Research Group based here in Washington, D.C. I have been working in the field of public and private benefit programs for more than 17 years. In fact, during my prior career with the Senate Special Committee on Aging, I spent a great deal of time in the oversight of the Social Security Administration's reviews of the mentally disabled and in the crafting of remedial legislation. So I am especially sensitive to definitions of mental illness that find their way into the law and how they can be turned and twisted in opposite directions.

With me today is Dr. Jack Mahoney. Jack is an M.D. and a M.P.H., a physician with broad experience in the fields of psychiatry, addiction medicine, and public health, who has been very active in the design of the latest generation of managed mental health programs in the private sector. He is based in our Connecticut office.

Hewitt Associates is an international consulting firm specializing in the design, financing, communication, and administration of employee benefit programs. We provide consulting services to over 75 percent of the Fortune 500 companies and have an active client base of over 2,000 employers. We have been in business for more than 50 years, and employ more than 3,500 associates in most of the states represented by this Committee.

We are honored to be here today. The subject of this hearing is one of the most difficult and important ones you will have to address as part of national health care reform. To his credit, President Clinton urged us all to engage in a constructive debate of his proposal and to be honest about those areas where we, collectively, don't have the answers.

We at Hewitt Associates do not represent anyone here today except ourselves. We are not doing work for any provider groups. We have no direct business interest in any managed mental health vendor relationships. We are not lobbyists or lobbying. But we do have an interest in sound public policies regarding the standard benefit package under health care reform, and we welcome the opportunity to share our professional expertise with this distinguished Committee as a public service.

What we will do today is draw upon our experience in designing mental health programs for large employee populations to give you some preliminary reactions to the design of the President's proposed mental health benefit; sketch out for you how we ourselves would go about designing such a package for a large employer; and illustrate for you how the costs of the benefit are dramatically affected by the particular design of the program.

Where we particularly add value is through our large private database and extensive experience in designing cost effective, high quality programs. Our actuarial model is based on data from our claims database of private employers' experience for active employees. Our current claims database includes data from employers that accumulates to eight million life years of experience. This data was supplemented by the actual, hands-on experience of our leading mental health consultants and actuaries, like Jack, who have helped large employers control costs through the introduction of managed mental health programs. With this model, we can determine the cost impact of changing both the plan design and the delivery of managed mental health benefits.

The experience of this latest generation of managed mental health plans will not be captured by the older, historical data sets and academic studies typically available and used by government actuaries and policy analysts. But we do have extensive experience with such programs and they offer some very positive opportunities for the Congress in designing mental health benefit options.

HEALTH SECURITY ACT

Over the last several months, we have observed the careful consideration and internal debate the Administration has given to its proposal. In fact, we notice significant differences between the mental health benefit as described in the preliminary 239-page draft specifications of early September, relative to the legislative language introduced on November 20, 1993.

Many of these differences reflect design improvements, in our opinion, and they strengthen certain broad concepts that would be very helpful in designing a national mental health benefit.

For example, the Health Security Act would cover inpatient and outpatient mental illness and substance abuse treatment, as well as less restrictive and less expensive alternatives to inpatient hospitalization. The earlier version had a reimbursement bias that favored inpatient hospitalization, but the recent legislative language attempts to correct for any such bias by:

- Limiting coverage to the least restrictive inpatient or residential setting;

- Giving the health plan the discretion to cover usually less expensive, intensive nonresidential treatment;
- Allowing for the substitution of 2 days of intensive nonresidential treatment for each day of inpatient treatment; and
- Allowing for the substitution of 4 outpatient visits for each inpatient day if it would cut down or eliminate more expensive hospitalization.

In other words, the Clinton proposal sets limits on what will be covered, as do more than 90 percent of large employer plans. But it does so in a way that attempts to give plans maximum flexibility to substitute more effective treatments and it provides for ways to override the limits where there is a medical necessity to do so.

Hewitt Associates maintains an extensive database on benefit plan provisions. We have information on the mental illness and substance abuse programs for 1,033 of the employers in the database. The data represents plan provisions from 564 indemnity plans (fee-for-service), 371 preferred provider organizations (PPO), and 98 point-of-service (managed care) plans. The following two charts summarize the special limits under the mental illness and substance abuse provisions of these plans.

Inpatient Limits

	Percent of Total
No special limits	7%
Limits for both MI and SA	82%
Special limits for MI only, no SA limits	2%
Special limits for SA only, no MI limits	6%
Other (e.g., limit for MI and SA not covered)	2%
Not covered	< 1%
Data not available	< 1%

Outpatient Limits

	Percent of Total
No special limits	4%
Limits for both MI and SA	87%
Special limits for MI only, no SA limits	5%
Special limits for SA only, no MI limits	1%
Other (e.g., limit for MI and SA not covered)	3%
Not covered	< 1%

This data indicates that most employer plans are in line with the proposed Health Security Act provisions which limit both mental illness and substance abuse services.

Even with all this flexibility, however, you should recognize that very many employees, particularly those with large employers or in union plans, will have more generous mental illness benefits than the Health Security Act provides. These employees would suffer a

benefit cut if they were required to obtain their coverage through the regional alliance, which most would be as the plan is written. Fortunately, there's an option to "fix" this problem, if the Congress were to incorporate a provision that Senator Kennedy, Chairman Waxman and others had included in their earlier versions of mandatory health insurance: actuarial equivalence. In other words, if current employees are receiving medical benefits that are actuarially equivalent or better than the standard benefit package under the Health Security Act, it makes little sense to force them to undergo a benefit cut or to restructure the plan into a basic plan and a supplemental plan that will not necessarily replicate what they have now. It would be particularly difficult to supplement the coverage differences in the mental illness/substance abuse benefit because of the limits on covered days and visits. In those situations where the current coverage is equivalent to or better than the standard package, employers should be permitted to continue offering that current plan.

Another good feature of the Clinton plan is that it allows for the coverage of case management, meaning the services that help individuals gain access to needed medical, social, educational and other services. This can be a very cost-effective way of directing patients to the needed services. Coupled with the coverage it provides for screening and assessment and crisis services, these features of the bill allow for a plan that is set up to intervene early in the episode of care and to mix and match the most effective combination of services. This treatment flexibility is extremely important to a truly cost-effective program. We have found that merely limiting the number of outpatient visits or severely limiting the coverage for mental illness and substance abuse has proven to be a short-sighted approach, producing some short-term savings without the appropriate treatment. The results tend to be high relapse and recidivism rates, with employees reentering the system on multiple

occasions for the same condition, ultimately compounding the long-term cost problem. As an alternative, managed mental illness/substance abuse treatment is clearly, in our opinion, the most cost-effective long-term approach.

In other words, using a state-of-the-art managed mental health plan design can result in substantially improved benefits for participants at the same or reduced cost. This is accomplished by reductions in inpatient and outpatient utilization, by resolving many individuals' problems with short-term interventions, by directing the longer-term, more serious treatment to appropriate providers, and by negotiating discounts with providers.

Finally, the Clinton plan recognizes that the impact of mental illness and substance abuse is felt not only by the individual concerned, but also by the person's family. And it would provide for the coverage of additional collateral services for the family members, for up to 30 visits of outpatient treatment. To illustrate the importance of this family treatment orientation, consider the results of a study for the McDonnell Douglas Company, designed and coauthored by my colleague Jack Mahoney. It found that the provision of managed mental health services to employees, including collateral services to dependents, saved even more on *dependent* medical claims (\$3 million over 4 years) than its considerable savings in *employee* claims (\$2.1 million).

We would also like to be clear about our use of terms. As far as the quality of care is concerned, we have noted a tendency to define "managed mental health care" as care provided through Health Maintenance Organizations (HMOs). We would like to emphasize to you that in our experience, the quality of care provided through a managed mental health

program can be superior to the average HMO's capitated approach. HMOs are paid a low flat fee per enrollee, and they "manage" mental illness and substance abuse by adopting a system of benefit design or utilization decisions that may, in effect, deny care; and certain poor outcomes, especially for the more serious or chronic conditions, have been documented by some recent studies.

In contrast, most of the major mental illness and substance abuse vendors manage care through true case management, beginning at the intake session, and they couple this utilization monitoring with discounted fee-for-service payments to providers. This allows for more appropriate and better quality treatment, but it costs more than HMOs typically spend for mental health care. The typical HMO targets a budget of approximately \$5.00 per member per month for mental illness and substance abuse spending (the actual number reported by InterStudy in 1989 was \$2.69). This level of HMO spending is lower than the cost per covered life in the managed mental health programs we are describing, which is about twice as high. Thus, the managed mental health programs save money long-term by making more effective use of resources, not by denying care in the short-term.

Unfortunately, the term "managed mental health care" is not used consistently. Many times it is used for a system which limits both access and treatment and shifts costs to the patient. We understand managed mental health care as a system which is optimized to meet the needs of the individual and resolve their psychiatric or chemical dependency condition with timely, appropriate treatment.

We believe this results in optimum efficiency and cost management. To accomplish this, the system must have an entry point, or gatekeeper, which is readily accessible. This gatekeeper must be able to determine the scope of the individual's problem, direct them to the appropriate treatment resource, and monitor their care. There must be a wide array of treatment options and providers to assure that the individual gets appropriate and high-quality care. Finally, since we are dealing with chronic and recurrent conditions, there must be ongoing case management and monitoring to assure that relapse and recidivism are minimized.

HOW HEWITT ASSOCIATES WOULD STRUCTURE A PLAN

Our observations about three cardinal aspects of mental illness and substance abuse are useful to restate, prior to discussing the structure of a mental health plan.

1. Mental illness and substance abuse are often chronic and relapsing.

While mental illness and substance abuse typically present themselves as acute conditions, in fact, the length of illness, or chronicity, is usually considerable. Studies conducted in the workplace have shown that individuals with these conditions often have evidence of impaired performance (absenteeism and increased use of health care resources) lasting from two to five years. The impairment may exist for a year or more before the affected person is no longer able to function and seeks professional assistance. That marks the beginning of the acute phase of treatment, which may take anywhere from a few weeks to many months, depending on the severity of illness, availability of resources and the appropriateness of the care given. With the exception of some minor conditions, treatment does not cease at the end of the acute phase. The person will

require additional support and/or monitoring services to resume normal daily tasks successfully and be productive. The sources of support include both mental health professionals and immediate family members. In some instances, especially with substance abuse and psychoses, there is a high probability of relapse that may precipitate yet another period of acute treatment.

2. These conditions affect entire families.

The person with a mental illness or substance abuse disorder has the potential to impact the physical and emotional health of coworkers and, most importantly, the person's immediate family. Again, workplace studies demonstrate a clear relationship between an individual family member being treated for a behavioral illness and increased medical claims costs for an entire family. These increased costs are commonly ascribed to physical conditions but may also be for behavioral health care.

3. Behavioral illness frequently coexists with other medical conditions.

Persons with these conditions typically seek medical assistance for a wide range of physical problems. These may be directly or indirectly related to the behavioral condition. For example, a person with depression may have a wide array of "ill-defined" physical complaints ranging from headaches to indigestion. There is a high probability that, absent intervention by mental health professionals, treatment for these secondary or associated physical conditions may continue for prolonged periods. Appropriate, effective treatment of the underlying substance abuse or mental illness can produce prompt resolution of both the behavioral problem as well as the physical condition. This is frequently referred to as the "offset effect." While mental health practitioners are well acquainted with this

phenomenon, we know of no study which firmly documents the exact magnitude of this offset on a national scale.

Given this knowledge and these observations, we would recommend the following structure.

ACCESS

We would recommend a minimum of financial and structural barriers to access care. Experience gathered in the workplace by Employee Assistance Programs (EAPs) has taught us the value of prompt, appropriate treatment delivered early in the progression of a mental illness or substance abuse condition. When addressed at this early stage, many problems (approximately 60 percent) can be resolved in no more than six outpatient therapy visits with the appropriate therapist. We believe such access is potentially available under the Health Security Act with the inclusion of screening, assessment and crisis services to be provided by all health plans. We would caution that to be effective, it is especially important that these services must be provided by persons who are specifically trained and have practical field experience. They should be professionals in the areas of social work, psychology, nursing or medicine and have special training in the area of substance abuse.

TREATMENT RESOURCES

Effective treatment under the plan should not be biased toward over-extensive use of inpatient facilities. Effective treatment is more dependent on a vast array of treatment modalities and professional skills. In most instances, these are best delivered in the outpatient setting. Therefore the language in the Health Security Act which encourages treatment in the least restrictive treatment setting is extremely useful, as is the ability to "swap" inpatient

treatment days for outpatient treatment sessions. It would be better, however, if the discretionary element were narrowed by appropriate treatment protocols, or some other mechanisms to ensure that discretion results neither in the routine denial of the care or in excessive utilization. The issue also has to be faced that there may be situations where individuals have exhausted their inpatient visits via the "swap," and later find that they are in desperate need of inpatient care nonetheless.

For those individuals who truly require inpatient care, the provision of 30 inpatient days per year, with the possibility of additional days if deemed necessary by a "professional designated by the health plan," is usually adequate. This said, we have concerns regarding the role of this "designated health professional." In current practice, decisions regarding appropriateness, or medical necessity, are made by a wide range of persons who are said to fit this description. The result, as we all know, produces marked inequities in care. We strongly believe there should be a uniform set of criteria promulgated by the National Health Board to guide the decisions of these health professionals.

Care must continue to be delivered after the acute treatment ends. Typically, this is a series of outpatient visits which are structured to meet the individual patient's specific needs. This could be accomplished through use of the Health Security Act's outpatient benefit or through "swapping" inpatient days for outpatient treatment visits.

Treatment must be available to persons who have a relapse or recurrence of their condition. Limitations on the number of treatment episodes are typically ineffective. We believe this is possible through the present language in the Health Security Act. However, we would raise

the same cautions mentioned earlier regarding the role of the "designated health professional" in assuring equity in application of this provision.

COLLATERAL SERVICES

We know that the "target" patient, as well as his or her family, requires attention and treatment. We would suggest the inclusion of collateral care services, as the Health Security Act does.

CASE MANAGEMENT

The availability of all of these services is not enough. They must be orchestrated and coordinated. In our experience, this case management function is essential if the individual is to receive appropriate and effective services at an acceptable cost. It is this management function which has led to the success of managed mental health services in the workplace. We are pleased to see this service included in the Act but would suggest that it might be more effective as a mandatory service provided by all plans. Employers who have "carved out" the mental illness and substance abuse care from the benefit plan and applied specialized clinical skills and utilization/cost methods report great success in controlling cost and improving quality. Very dramatic decreases in cost have been reported, though the results can be quite variable across companies.

COST OF MANAGED MENTAL HEALTH BENEFITS

As an illustration, Hewitt Associates has used our actuarial model to give a preliminary price of the plan the Administration is currently recommending for coverage of mental illness and substance abuse benefits.

After illustrating the cost effects, we would also like to address some of the concerns that have been expressed with respect to service capacity.

COSTS AND UTILIZATION

The description of benefits payable under the Health Security Act and their interrelated limits on services is not a typical design of current employer plans. As such, we have taken liberty to make "conservative" interpretations of the provisions to fit our standard actuarial pricing model. These assumptions are described in a later section of this testimony (Appendix A). (Modifications of those assumptions would naturally raise the pricing to varying degrees, so Congress would be well advised to introduce as much precision as possible in defining its intent.)

We have taken the approach of developing costs for the Health Security Act plan provisions based on two different scenarios for managing the same covered services: First, we priced an "unmanaged" plan at \$210 per covered life under the high cost-sharing plan in 1994. Then, we priced a managed plan at \$143 per covered life. The estimated cost under the low cost-sharing plan is \$164 per covered life. The low cost-sharing plan cost assumes the same level of utilization savings and discounts as the managed high cost-sharing plan. These costs are based on claims data provided to Hewitt Associates from large employers in the United

States. We have not attempted to adjust these costs for the potentially different utilization experience of the non-working or the uninsured populations.

If we took the 50 percent outpatient benefit and increased the benefit to 80 percent, the cost per covered life (in 1994 dollars) would rise to \$235 under the unmanaged high cost-sharing plan; \$162 under the managed plan; and \$173 under the low cost-sharing plan.

If we made the outpatient benefit unlimited visits at 80 percent coinsurance and made inpatient days unlimited, the cost per covered life would rise to \$263 under the unmanaged high cost-sharing plan; \$188 under the managed plan; and \$197 under the low cost-sharing plan. This cost is close to what the mental health benefit would cost (in 1994 dollars) in the year 2001, when the benefits are scheduled to increase under the proposed Health Security Act.

Hewitt Associates does not keep a database on the uninsured population's medical costs, and there is uncertainty and disagreement about how much additional mental health benefits the uninsured population might be expected to use, when they receive coverage. If one assumes (as some studies have found) that the uninsured population would cost 20 percent more than the currently insured population, and if 15 percent of the population is uninsured, then the additional cost per covered life would be 3 percent higher than the figures we have provided above. That additional cost, however, does not reflect total public and private spending for the severely mentally ill.

Our pricing of the mental illness/substance abuse benefit in H.R. 3600 is very close to the \$256 price per single person, which has been reported to be the Administration pricing. When we take our costs per covered life (which is by definition an average of adults and children) and convert them to a premium for single adults, our price for the unmanaged mental illness/substance abuse benefit is \$242 for the insured population; and if we increased the cost for everyone by (for example) 6 percent to reflect higher utilization of mental illness/substance abuse benefits by the currently uninsured and underserved, our price would be \$257 per single person. But where our estimates differ more importantly from the Administration's is that we see a large potential for reducing those costs if the benefits were managed properly. So we would like to discuss such managed mental illness/substance abuse programs at length.

Most importantly, these scenarios provide an indication of how different the resulting cost can be under the same level of plan design but under different levels of managed care.

HEALTH SECURITY ACT PLAN DESIGN

In addition to pricing both the high cost-sharing and low cost-sharing model of copayments and coinsurance, we have also included the following limits on care for mental illness and substance abuse services, as based on the Health Security Act.

Inpatient, Residential, and Intensive Nonresidential

- 30-day annual inpatient limit (with additional 30 days per year under somewhat limited circumstances and at the discretion of the health plan professional).

- 120-day annual limit on intensive nonresidential treatment as an alternative to hospitalization, and at the discretion of a health professional designated by the plan.
- One-day reduction in inpatient limit for each two days nonresidential for first 60 days; and 60 additional days at the discretion of the health plan professional.
- One-day inpatient deductible (under the high cost-sharing plan only) for each episode of inpatient/residential and intensive nonresidential mental illness and substance abuse treatment.
- 20 percent coinsurance for inpatient/residential treatment and for first 60 days of intensive nonresidential.

Outpatient

- 30 visits outpatient psychotherapy (additional discretionary visits of up to 120 visits allowable as an alternative to hospitalization and at the discretion of the health plan professional, and reducing the inpatient day limit by one day for each four outpatient visits so authorized). Also 30 visits for collateral services to family members.
- 50 percent coinsurance (20 percent in the year 2001) for outpatient psychotherapy and for collateral services.

Improvements in Benefits in 2001

- Annual limits on inpatient and outpatient treatment are removed in 2001.

- Coinsurance for outpatient and for intensive nonresidential treatment are reduced to 20 percent.
- Deductibles, copayments and coinsurance for outpatient mental illness and substance abuse benefits and for intensive nonresidential treatment apply to overall out-of-pocket maximum of \$1,500 individual and \$3,000 family in the year 2001.

We have also assumed that standard insurance industry reasonable and customary (R&C) fees will be allowed as a covered expense and that there are no maximum dollar limits on any service (outside R&C limits).

UTILIZATION SAVINGS

The degree of savings achievable by the different levels of managed care can be very dramatic. In a moderately managed program with a utilization review plan that monitors all mental illness and substance abuse treatment and directs appropriate care on an as needed basis, overall costs are reduced from five to ten percent (most of which is coming from inpatient costs).

Under a program with a well-managed employee assistance program and utilization review with preferred discounting, an employer can expect total reductions of 30 to 40 percent on inpatient costs and 10 to 20 percent on outpatient costs. Overall costs may be reduced in the range of 25 percent to 35 percent.

We have reflected both anticipated utilization and provider discount savings in our cost estimates. The costs provided in our testimony are based on the claims experience of large employers. It does not include data on the currently uninsured and non-working population.

We have assumed the following utilization savings and discounts under the two scenarios:

	Unmanaged	Managed
Inpatient utilization	0%	30%
Inpatient discounts	0%	25%
Outpatient utilization	0%	0%
Outpatient discounts	0%	10%

In addition, we have also anticipated higher administrative costs (e.g. \$30 per covered life per year) under the managed care scenario to reflect the costs to run a provider network and provide assessment, referral, ongoing review and management services.

MANAGED MENTAL HEALTH CASE STUDY

In our experience, there are many case studies that can be reviewed to substantiate the assumptions chosen in our analysis. The following provides highlights from one company who began implementing varying forms of managed mental health benefits in 1987.

In one location, they observed an overall 67 percent reduction in costs in the first two years of the program. The costs have continued to decline at an average rate of 13 percent per year. First year reductions were similar at two other company locations.

The admission rates for locations adopting the managed program decreased by 45 percent, on average, between 1990 and 1992. Other locations that did not adopt the managed program increased 17 percent during the same time period.

Certainly upward adjustments in the cost of all these plans should be made to reflect new pools of uninsured individuals. Still, the overall cost relationships are roughly the same. In fact, we would expect the managed mental health plan design to compare even more favorably to the indemnity plan where the pool of enrollees includes relatively more high users of mental health benefits.

MANAGED MENTAL HEALTH SERVICE CAPACITY

When the subject of managed mental health comes up in Washington, we sometimes hear comments about the current limitations on service capacity for a nationwide system of managed mental health care and concerns about the quality of care provided through managed care organizations.

While we would agree that the service capacity does not yet exist nationwide, we have found that it is much more extensive than government policymakers often think. Already there are approximately 30 large vendors supplying these services nationally, and hundreds more operating on a local or regional basis. In 1992, there were more than 78 million people enrolled in managed behavioral health care programs, "behavioral health" being a catch-all term including mental illness and substance abuse. These programs consist of behavioral health PPOs, utilization review and case management, and EAPs.

We also would think that the capacity would continue to grow quickly under the Clinton Administration's plan to promote integrated systems of care through regional health alliances. The current design of the benefit also would create financial incentives to hasten the development of managed mental health care. The "managed mental health plan" could be offered, provided it is "certified" as having the appropriate vendors and medical providers with credentials. Standards for certification could be established by the Federal Government. (We have already developed criteria that large employers use to select a high quality vendor.) Where such "certified" plans do not exist, participants would start to demand them (because they would get better mental health benefits), and providers would want to supply them (again, because they allow for more flexible and appropriate treatment patterns and schedules). So where we start out with no certified plans, we would quickly move toward them, given the financial incentives created by the existence of the managed mental health plan option.

We are finding that mental illness and substance abuse treatment providers have begun to actively seek out opportunities to join major managed mental health networks. In part, their motivation is one of economics. As we have seen, the managed mental health networks control vast numbers of individuals, many of whom are the providers' own existing patients. In some cases, survival dictates joining the network to keep the patient. In other cases, providers will join the network out of consideration for their existing patients, who will receive higher reimbursement if the provider joins the network.

The practical experience of the network providers has also become quite good. For example, we just did an on-site audit of a managed mental health network for a large employer. We

pulled, at random, 40 provider files, to check references and credentials. Of these 40, only one had less than five years of experience in the field. The remainder had a minimum of 10 years. One psychiatrist had 25 years of experience.

Also, we would point out that this service capacity would not be created from scratch. It is not a question for managed mental health programs of creating additional provider capacity, as there is for primary care, for example. Instead, what needs to be created is management capacity. The development of such capacity could also be fostered by the regional purchasing alliances, who might even, as a transitional device, develop outside management capacity that could serve all the plans within the alliance who choose to take advantage of it.

CONCLUSION

The Health Security Act contains many positive concepts for the design of a mental health benefit program. We have tried to describe how we would take those components of a good system and structure them into a cost-effective program. Lots of questions still require answers, notably, what the costs would be for the severely mentally ill and the short-term and long-term utilization of mental health services by the currently uninsured population. Still, the current environment allows the Congress to address the critical need for mental illness and substance abuse services and to control its cost by creating incentives to manage the care in a cost-effective, high quality mode. National health care reform legislation should include a managed mental health benefit alternative along with the indemnity plan option. The principal reason is that current, state-of-the-art managed mental health plan designs would allow health plans to offer plan participants more generous benefits at a relatively lower cost. And if the proper standards are set for those who manage the care, quality may be improved.

APPENDIX A

Methods and Assumptions

The low cost-sharing option has been priced assuming today's level of provider discounts and expected utilization savings from the managed environment. Our pricing assumes a gatekeeper arrangement with strong financial incentives for the primary care physicians. If alliances can negotiate lower fees to begin with, the costs would be lower.

A possible result of regional alliance negotiations for both fee-for-service schedules and managed care discounts is that price differences in the two may narrow. This may result in lower fee-for-service costs relative to the lower cost-sharing managed care plans.

The pricing models used for this analysis are based on claims data collected for the 1990 and 1991 calendar years. They have been trended forward at 12 percent per year to represent expected covered expenses for the 1994 calendar year. For mental illness and substance abuse claims specifically.

Data Sources

The actuarial pricing models are based on data compiled from Hewitt Associates **Health Information/System™** database. The data represents roughly 8 million life years, both adult and child, for the 1990 and 1991 calendar years. The claim volume is over \$11 billion, covering all categories of medical expense. Data was reviewed for reasonable allocations by service category (e.g., inpatient, surgical, drugs, mental health), and employee relationship (e.g., employee, spouse, and children).

Pricing Models

The pricing models developed by this data are structured in the following functional components:

- Primary health care benefits with deductible, coinsurance, other copay, and out-of-pocket variables;
- Prescription drugs (if not included above);
- Mental illness and substance abuse treatment; and
- Lifestyle-related benefits.

The above models are distinct components of the system but are interrelated with each other. That is, the level of covered expenses used in the primary pricing model influences the level of benefits in the other models.

The models are set to develop prices for the 1993 calendar year. Costs shown in this testimony used 1994 as the basis for costs. Covered expenses for mental illness and substance abuse were trended forward from 1993 at a 12 percent rate.

Assumptions

The plan provisions included in the Health Security Act are not commonly found in today's mental health programs. We have therefore made assumptions regarding the operation of the plan to "fit" our basic pricing models. The following summarizes the key assumptions made in our analysis.

Inpatient Benefits

Inpatient deductible	\$750 per year (applicable to high cost-sharing plan only)
Coinsurance	80 percent (high cost-sharing plan)
Effective out-of-pocket limit	\$1,125 (75 percent of \$1,500 OOP limit applicable to whole plan); \$900 (60 percent of \$1,500 in year 2001)
Annual limit	45 days (to account for 30 day limit, discretionary days, intensive nonresidential treatment) / None (2001)
Total discounts	None (25 percent savings for managed plans)
Utilization adjustment	None (30 percent inpatient reduction for EAP for managed plans)

Outpatient Benefits

Effective deductible	None
Coinsurance (high cost-sharing)	50 percent (initial) / 80 percent (2001)
Copay (low cost-sharing)	\$25 per visit (initial) / \$10 (2001)
Effective out-of-pocket limit	None (initial) / \$900 (60 percent of \$1,500 OOP limit applicable to whole plan in year 2001)
Annual limit	45 days (to account for 30 day limit, discretionary days, intensive nonresidential treatment) / None (2001)
Total discounts	None (10 percent savings for managed plans)
Utilization adjustment	None (None for managed plans also assuming 20 percent more outpatient care but 20 percent lower average number of visits)

Administrative Expenses

We have assumed that administrative expenses will be equal to 8 percent of total premium for the unmanaged plans and \$6.50 per month per employee (as distinct from per covered life) plus 5 percent of incurred claims for the managed plans. The \$6.50 fee is an average fee for a stand-alone managed care vendor that provides an employee assistance program, network management and utilization review for a program. The 5 percent of incurred claims amount is primarily for claims administration and some reporting.

APPENDIX B

The following represents data from 150 randomly selected companies in the 1993-1994 Hewitt Associates' SpecBook™ (1,034 employers total).

Inpatient Limits for Mental Illness and Substance Abuse

No special limits	8%
Limits for both mental illness and substance abuse	84%
Special limits for mental illness only, none for substance abuse	1%
Special limits for substance abuse only, none for mental illness	5%
Other (e.g., limit for mental illness, substance abuse not covered)	1%
Mental illness and substance abuse not covered	1%

Outpatient Limits for Mental Illness and Substance Abuse

No special limits	4%
Limits for both mental illness and substance abuse	85%
Special limits for mental illness only, none for substance abuse	6%
Other (e.g., limit for mental illness, substance abuse not covered)	4%
Mental illness and substance abuse not covered	1%

Lifetime Dollar or Day/Visit Maximum

Inpatient mental illness	65%
Inpatient substance abuse	67%
Outpatient mental illness	47%
Outpatient substance abuse	47%

Annual Dollar Maximum

Inpatient mental illness	19%
Inpatient substance abuse	18%
Outpatient mental illness	59%
Outpatient substance abuse	54%

Annual Day/Visit Limit

Inpatient mental illness (median=30 days)	
<30 days	10%
30 days	44%
>30 days	46%
Inpatient substance abuse (median=30 days)	
<30 days	11%
30 days	49%
>30 days	40%
Outpatient mental illness (median=50 visits)	
<30 visits	21%
30 visits	12%
>30 visits	67%
Outpatient substance abuse (median=50 visits)	
<30 visits	22%
30 visits	7%
>30 visits	71%

Coinurance

	Inpatient		Outpatient	
	MI	SA	MI	SA
50%	1%	1%	33%	23%
60%	1%	1%	1%	1%
70%	3%	3%	2%	2%
75%	1%	1%	1%	1%
80%	60%	57%	28%	35%
85%	3%	3%	—	1%
90%	21%	22%	10%	11%
95%	1%	1%	—	—
100%	4%	4%	8%	9%
Declining scale	4%	6%	16%	13%
Not covered	1%	1%	1%	4%

Copayments Required

Inpatient mental illness	1%
Inpatient substance abuse	2%
Outpatient mental illness	12%
Outpatient substance abuse	11%

Cover Nonresidential Treatment

Data not available

Substitute Intensive Nonresidential for Inpatient

Data not available

Mr. WAXMAN. Mrs. Obrochta.

STATEMENT OF CAROL OBROCHTA

Mrs. CAROL OBROCHTA. Good afternoon. Thank you for inviting me to share my family's experiences with you. My name is Carol Obrochta. I am from Richmond, Va., and I work for the Federation for Families With Children With Mental Illness.

I am the mother of three daughters. My oldest daughter Betsy will also speak with you.

When Betsy was 18 months old her pediatrician told me that no one should have to live with a child like that, and prescribed medication to, in his words, tone her down. I decided not to medicate my baby, but spent much of the next 15 years seeking appropriate help for her. Her diagnosis has changed periodically over the years, but bi-polar disorder probably is the most accurate.

Betsy experiences mood swings, rages, and often very difficult behavior. She is exceptionally bright with a terrific sense of humor and cares very deeply for others.

Betsy was receiving outpatient therapy by the time she was 4 and had a series of therapists throughout the years. Sometimes it was covered by our insurance. I covered co-payments as well as full charges during a period when we had no mental health benefits. Our Blue Cross Blue Shield policy has an annual outpatient therapy limit of \$1,000.

During the years, Betsy became more and more difficult. By the time she was 11, she was actively suicidal. By age 16, things were really out of control. Betsy was receiving outpatient counseling, mostly at our expense, three times a week. Following a suicide attempt at age 16, she was hospitalized, first in a medical hospital receiving immediate medical attention and then at a private psychiatric hospital. She was also receiving treatment for substance abuse at that time, which was closely tied to her mental health problems.

At that point, the recommendation was made to seek permanent out-of-home placement for Betsy. It was feared that her violent behavior was not manageable in a home environment, and that our family had done all that we could with our emotional and our financial resources.

Betsy was scheduled to enter a State hospital, with us frankly searching for long-term placement for her. After deep consideration, my husband and I decided to bring Betsy home, against the advice of all of the professionals who were working with her.

We searched for a day treatment program for her, determined to provide structure and support. We knew this was our last chance. There was a program in a neighboring community, but we were not allowed to participate because of residency requirements.

Finally, we were successful in locating a program. Our insurance company would not pay the expenses for this intensive outpatient care, although it was significantly less expensive than the inpatient treatment that they had covered.

The program was successful beyond our wildest dreams. The daily support and structure worked for her where all else had failed. Involving the entire family in the treatment process added to the effectiveness. For a relatively low financial expense, we were

able to keep our daughter at home and our family intact. The benefits from that have greatly reached everyone in our family, and I think particularly Betsy's two younger sisters.

I am concerned that the proposed mental health benefits under the health care reform are restrictive and limited in their scope. Many nights I wished that my child had a visible disability that would allow her access to appropriate supports and services. Mental health programs need to be appropriate and they need to be accessible to all citizens. We can't afford to wait.

In my work with other families throughout the Nation, it is not surprising that an intensive day treatment program was successful for us. Keeping children in their homes and communities is vital to effective mental health treatment. Families also need to be able to receive access to appropriate care.

After years of struggling to help my child, I am grateful to be able to say that once we found the right program for her, it worked. We have had many, many successes. Betsy is a full-time college student, she is working part-time, and she is paying taxes. She is also an advocate for flexible mental health services for children, adolescents and their families.

Ms. BETSY OBROCHTA. My name is Betsy and I am a 19 year old sophomore at Virginia Commonwealth University. I have been in therapy for about 15 years, and I think I did gain most of my help in recovery, and it is due to the outpatient day treatment program I was in.

There I learned to cope with the day-to-day problems and routines and learned how to communicate with my family without being in a controlled environment like when I was in the hospital. My family and I were able to work things out as problems arose, and there was no one there to tell me if I was speaking correctly or not. They were there just to listen and to guide us along.

And I was able to have the freedom to go to school and to live a normal life, which was very important to me. I needed to be surrounded by my friends and family in order to really grow in my recovery. I think this outpatient care was the help that I needed to be the person that I am today.

The intensive day-treatment program gave me independence. Hospitalization was just too isolating and restricting, and standard outpatient therapy just wasn't enough to really help me with the serious problems that I was going through.

I give credit for my success for hard work from me, as well as to having the right type of resources available to me and to my family.

Mr. WAXMAN. Thank you very much. That is what we have got to try to do is to get the right resources to people so that it will help them, resources that they can use, will be convenient and will be effective.

I think that is the challenge we have and I appreciate you coming and telling us about your own experience.

As we look at how to develop health security, which means the security of having mental health services as well as other services, there seems to be some notion of putting limitations on arbitrary limits on costs, the cost impact of placing arbitrary limits on the treatment.

Dr. England, do you think there is a fundamental difference that you have with the administration on this point? Do you think that if we had organized systems of care, we could avoid the need for limits, while maintaining quality and holding down costs?

Ms. ENGLAND. I think for the amount of money that has currently been put into the budget of \$240, \$250 out of an \$1800 premium that we can provide full and comprehensive services to all Americans, for both mental health and substance abuse services.

There is data in the private sector looking at the working population, there is data in the public sector, certainly for the severely mentally ill children. We have data that we have obtained from the Medicaid program throughout this country, as well as for the severely mentally ill adult. When you put that all together, the questions that were asked earlier, none of us can understand how they come above \$240.

So that is why I have requested that if in your wisdom you would ask the National Institute of Mental Health to tell you what they think could be purchased under \$240. But yes, we do have a difference. I do feel we can provide a comprehensive package.

Mr. WAXMAN. Mr. McArdle, maybe you would like to comment on this. Are limits the only way to hold down costs or do you think we can do it with the same amount of money that is being allotted?

Mr. MCARDLE. No, Mr. Chairman, limits are not the only way to hold down costs. I think you will find that limits are common right now in the workplace that lists the kind of limits you will find in the employer workplace. Many times the limits are higher than the limits that are in the Health Security Act.

But the real point is that if you manage the care properly, then you don't need the limits. We were talking at lunch about the previous witness who had care for about 12 months, as I recall, at \$64 a day, and we figured out over that long period of time, it would equal the cost of one hospitalization at 30 days.

So what you need, and Jack can tell you more about this, is you need the flexibility, you need a qualified person who can say for this individual, 15 months at \$64 a day is a better cost effective alternative than 30 days in a hospital, and that is the kind of management you need in the system.

We also priced the new plan that was introduced in November compared to the October draft where they lowered the limits, and the effect of lowering those limits lowered the price of the mental health benefit in our pricing by about 7 percent. That means for the total benefit package, it lowered the cost by less than 1 percent.

So those limits that they put in did not save a lot of money in our opinion.

Mr. WAXMAN. How should that be done? Should it be done by a case manager?

Mr. MAHONEY. We believe strongly that case management is a much more effective way of managing the costs by identifying what the individual needs, identifying the appropriate resources, and getting them there and making sure that they have access to those resources. You will meet the financial goals, at the same time resolving the individual's mental health or chemical dependency problem.

I think limits, especially day limits, are very arbitrary, because it is one size fits all. I think for those of us who have practiced in the area of mental health, we know that every case is very different, it is very hard to categorize them, it is very hard to come up with an arbitrary length of treatment.

I think we need to be able to respond to that. The experience in the private sector has been that if a managed mental health system is constructed with meeting the individual's needs, that you can still achieve dramatic cost savings, manage the benefit in a very effective financial envelope and still have very, very good results for the individual.

Mr. WAXMAN. Mr. Dalton, maybe you can respond to this. In the absence of substantial change in the mental health benefit, would you agree that States will continue to assume major responsibility for caring for those seriously ill patients who have exhausted their benefits, and would you agree that the proposed benefit is not designed to serve the needs of patients with serious mental illness?

Mr. DALTON. Yes, and yes to both questions, briefly. States have had a traditional responsibility to the most severely disabled and it is one that they should not relinquish or change in perhaps the mix of what will go on into the future.

They should also not lose their ability to avail themselves of other benefit packages. It really goes back to the two questions that have to deal with the question that you asked before, which is is there a way, besides a benefit limit, that will make sure that we can broaden the delivery of services to those people that are in need, most of whom by the way are very low income or are our Nation's working poor families.

There are a couple of other approaches, and both of them are contemplated and must be supported. One of them is managed care, that if you have a system that takes a look at it, whether it is case management or whether it is something like a sufficiently strong database so that you will be ultimately buying the right services over time, and those will have to be cost-effective, and that it is capitated.

It doesn't matter whether the baseline provider does a fee-for-service approach to business, but States or jurisdictions must be able to say that these are the resources that we have, and now we will manage them as best we possibly can. And if you put in some sort of an arbitrary limit, then that will take us off the hook, and it will force us to move people back into somehow a nonintegrated public system that will become second fiddle to this whole process.

Global budgeting, capitated services, managed care, all must be in place and must include public sector as well as the private sector in this area. It has got to be integrated in that fashion.

Mr. WAXMAN. Mr. Kreidler.

Mr. KREIDLER. I will pass. Thank you, Mr. Chairman.

Mr. WAXMAN. Mr. Brown, did you want to ask questions?

Mr. SHERROD BROWN. No, I have no questions.

Mr. WAXMAN. Let me just ask one question. The proposed health benefit rejects at least initially the principle of parity with mental health.

How does the effectiveness of treatment compare with conventional medical interventions? Are there any legitimate scientific or

medical considerations for delaying implementation of a benefit based solely upon parity than between mental and physical health? Dr. England?

Ms. ENGLAND. There is no science that says that we should delay the implementation of this benefit. In fact, now that I have had the opportunity to work in both med-surg and mental health, there are very good studies that show the effectiveness of mental health treatment.

Over the last 20 years we have advanced tremendously in our ability to treat mental illness and there is very good outcomes research that shows we can be very effective. In fact, our large corporations have put in outcome studies and have asked their providers of care to put in research studies. Digital recently did that in the area of depression, showing that if you can pick up depression early and treat it effectively, you can reduce the amount of days lost at the worksite.

Most people don't know this, but the single cause of lost time at the workplace is due to depression. So there are lots of other costs in fact. We do know what we are doing, we have very good outcomes, as good as they do in the area of medical and surgical intervention.

Mr. DALTON. Very quickly, there has been a model study that has shown that for a diagnosed but untreated incident of depression, a person who is in a hospital for some other unrelated medical condition doubles the length of stay on the medical condition.

Mr. MCARDLE. Jack can talk to you from a physician's point of view, but I would like to give you one example. A woman made a suicide attempt and went in and was seeing a psychiatrist for outpatient psychotherapy and the limit under her plan was \$1,000.

Now, if there were any other life threatening illness, heart, kidney, whatever, the system would have paid hundreds of thousands of dollars to treat that woman. But because it was a psychiatrist, it was limited to \$1,000, which for me, anyway, brings home the discrimination aspect of that. Jack?

Mr. MAHONEY. I think just to piggyback on what Dr. England was saying, we know the outcome of mental health and chemical dependency treatment. What we tend to lose sight of is that these conditions don't exist in a vacuum.

Frequently the individual, in addition to a mental health or chemical dependency problem, has medical problems. To the extent we postpone or delay treatment to those—and we know this happens in populations we have looked at, if we cut back their coverage for mental health chemical dependency treatment, they incur more costs for routine medical care.

We need to look at the individual as a whole.

Mr. WAXMAN. Do you want to say anything on this point?

Mrs. CAROL OBROCHTA. I think our story speaks for itself.

Mr. WAXMAN. I thank you all. You have been terrific witnesses and I appreciate your testimony.

Our final panel we will hear from witnesses about general benefits. Dr. Robert Putsch is a physician from Seattle, Wash. and Director of the Cross Cultural Health Care Program. His testimony will focus on the need for translation and interpretation services as part of the benefit package.

Mr. Lawrence Hill represents the Coalition for Oral Health. He is the President of the Association of Community Dental Programs as well as dental director for the Cincinnati Health Department.

Dr. Michael D. Parkinson represents the American College of Preventive Medicine; and Dr. L. Edward Elliott is the past president of the American Optometric Association.

We are pleased to have the four of you here today. Your prepared statements will be in the record in full. What we would like to ask of you is to limit the oral presentation to no more than 5 minutes.

Dr. Putsch, why don't we start with you?

STATEMENTS OF ROBERT W. PUTSCH, III, MEDICAL DIRECTOR, CROSS CULTURAL HEALTH CARE PROGRAM, PACIFIC MEDICAL CENTER; LAWRENCE HILL, PRESIDENT, ASSOCIATION OF COMMUNITY DENTAL PROGRAMS, ALSO ON BEHALF OF COALITION FOR ORAL HEALTH; MICHAEL D. PARKINSON, MEMBER, BOARD OF REGENTS, AMERICAN COLLEGE OF PREVENTIVE MEDICINE; AND L. EDWARD ELLIOTT, PAST PRESIDENT, AMERICAN OPTOMETRIC ASSOCIATION

Mr. PUTSCH. Chairman Waxman, thank you for inviting me. I am at the end of my trip from Seattle, and this is just in time before I will be ready to sleep again on the plane going home.

I would like to thank you and your professional staff member, Julia Fortier, for bringing this issue to the committee, because I think that it has been an issue that is under represented in our current funding systems and almost dangerously so.

Just to give you a sense of the context we had in one of our major referral hospitals just the last 2 weeks, a youngster who was having cardiac surgery, a child of a migrant farm working family, a Spanish speaking pediatrician was making a visit about 72 hours into the hospitalization. The child was still doing poorly. And he asked the nurse about communication with the family. She replied that there are two bilingual janitors on the floor who have been helping, that the 11 year old sister has helped at times, and when they are not available, they are likely to call on a bilingual nurse up in the anesthesia department.

The problem for families in this kind of a setting is extraordinary. They are under stress, they have no sense of continuity or trust in the messages that they hear, often put their family in danger. And I think that those of us who have been patients, and most of us have at one time or another, can reflect very quickly on what it is like to have a message muddled or changed or have a sense that we are not being listened to.

Communication problems are complex enough without language barriers or cultural barriers added on top of them.

I would like to focus briefly on some problems that we have experienced recently with demography. We have had, after the fall of Saigon, a number of new languages that weren't represented in our community clinic systems. The new Chinese dialect for us was Choujho. We had already had Cantonese speakers, but there were a lot of Choujho speakers that came out of Vietnam and Cambodia.

On top of that, we had a number of Hill Tribe groups represented, including the Mhong, Mehan, and then a large number of smaller groups in our community, Khmou, Li Sutin and Pare

and Lao. Most of these individuals communicate in Lao, which is their second language.

The difficulty with these groups is that they come from nonwritten language groups, very much like the Navajo have in the past, and when we try to use terminology like allergy, anxiety, depression, these are terms that are missing in their system. In order to explain these terms or even negotiate about the question of what is wrong, we are also confronted on the other side with a very complex lexicon in which the patients and families use their own systems to define etiologies.

And then during the last few years, we have had even more complexity in language, because we have had Eastern Europeans, people from Africa; our clinic is now seeing Aroma, Somali, Tigre, Mhark speakers, and we had a new contingent of Haitians arrive in Seattle.

There is a lot of geographic difference in this. We talk to the people in Boston who have a large contingent of Cape Verde Islanders. A lot of hospitals have been heavily impacted by this, and I think that there has been sort of a disparity in some of the degree to which a hospital has been willing to pick up the responsibility.

Just the absence of translating systems in a hospital is likely to unburden that hospital from the perspective of picking up a community workload. The reverse is also true.

The way in which hospitals have dealt with this has depended greatly in my view on responses from the Office of Civil Rights. Most of the functional programs that we see have been put in place because of civil rights complaints. We are aware of somewhere between 50 and 60 settlements that have occurred around the country, and some of them at fairly large expense to the hospitals involved.

Formerly organized interpretive programs are really an exception rather than the rule. There are very few sites that have organized interpreter programs that are training their providers how to use interpreters, and that are upgrading in assessing the skills of interpreters, even testing interpreter skills is a limited and tenuous function.

Currently there are a number of systems that are engaged in litigation over these issues, and so this is an ongoing struggle. I want to point out that language plays a major role in access to health care and in preventive health care.

I want to leave you with three critical points that I think we need to remember. One is that the absence of adequate language services may severely limit health care access, and places patients at greater risk. The second is that we are required to provide language services by nature of the Office of Civil Rights and the Civil Rights Act of 1964. Third, there is no real source of funding for these services short of including them in any plan for health care package.

In our view, this needs to be required rather than placed in the package as an ancillary service.

Mr. WAXMAN. Thank you very much.

[The prepared statement of Mr. Putsch follows:]

Testimony regarding language barriers and interpreters in health care. The United States House of Representatives, Committee on Health and the Environment, December 8, 1993.

Chairman Waxman, I would like to thank you and particularly your aide, Julia Fortier, for considering the issues of language and communication across cultural and linguistic barriers as a part of the work of this committee. Preparation for the hearing has brought to mind a recent episode in one of our major pediatric referral centers on the West coast:

The child of a monolingual, Spanish speaking migrant farm working family had undergone major cardiac surgery. In the post-operative period, while the child was still critically ill, and the physicians were unable to get the child off the ventilator, the attending pediatrician asked the intensive care nurses about their communications with the child's family. "There are two janitors in the area who speak Spanish and the 11 year old brother speaks good English...if we can't get one of them to help, we call up to the recovery room, they have a Spanish speaking nurse up there." The care process had not included a trained medical interpreter. Asked why the interpreter pool had not been called or involved in the care process, the head nurse replied: "We are trying to save money."

Unfortunately, this case illustrates the state of interpretive services in many health care settings. It is repeated over and over on a daily basis around the country. Even in communities where organized interpretive services are available, hospital and clinic staff are often unaware of their obligation to provide adequate interpretive services. This process places patients, families and health care system at great risk. It does not meet with guidelines established by the Civil Rights Act of 1964.

Language is a major barrier to accessing health care for non-English speaking populations. Lack of linguistically and culturally appropriate services are major sources of failure in acute and preventive health care services. This problem has a long history in the United States. In 1964, Levy pointed out that on the Navajo Reservation "there are no Civil Service positions for interpreters on the reservation, no on-going in-service training programs in interpreting techniques...what attempts have been made were invariably short lived, and with little influence on governmental programs in general."¹ Writing in the 1960's about language on the Navajo reservation, Young observed that *cross-cultural interpretation requires special training and highly developed skills. Just any bilingual person, chosen at random, is not sufficient.*² Young and Levy's observations are correct and apply just as clearly today.

Communication in health care is a complex issue. Language and cultural barriers complicate the situation. Language is the framework in which the world view of a culture is molded, and it describes the boundaries and perspectives of a cultural system.³ A language barrier disarms a communicant's ability to assess and convey meanings, intent, emotions, and reactions and creates a state of dependency on the individual who holds the keys to the entire process—the interpreter.

Interpretation requires a great deal of skill. Interpreters find it necessary to describe and explain terms, ideas and processes that lie outside of the linguistic systems of clients. The interpretation process must account for divergent world views. Individuals and cultures have varying perspectives regarding the cause, presentation, course, and treatment⁴ of sickness, as well as the

¹ Levy, J: Interpreter Training Program. Window Rock, Arizona, Public Health Service, Division of Indian Health, 1964, p 1.

² Young, RW: *English as a Second Language for Navajos: An Overview of Certain Cultural and Linguistic Factors*. Albuquerque, Bureau of Indian Affairs, 1968, p.17.

³ Whorf, B: *Language, Thought and Reality*. Cambridge, MA, The MIT Press, 1956.

⁴ Kleinman A: *Patients and Healers in the Context of Culture: An Exploration of the Borderland Between Anthropology, Medicine and Psychiatry*. Berkeley, University of California Press, 1980, p. 105.

risk it represents to others. We are aware of cases in which failure to communicate and to use adequate interpretive services has led to major medical and psychiatric catastrophes including death.

I'd like to focus briefly on issues of demography. After the fall of Saigon in 1975, we experienced an influx of new cultures, languages, health beliefs and practices. Viewed simply as national groups, the Vietnamese, Lao, and Cambodians seem to represent a limited number of languages. However, these groups included ethnic Chinese who spoke Cantonese and Chao-jo, as well as hill tribe and religious minority groups that added further to problems with communications. These later included the Hmong, Mien, and Cham (an ethnic minority of Moslems from Vietnam and Cambodia) as well as scattered numbers of smaller tribal groups such as the Khmu, Lisu, and Lu. The hill tribes each had their own language; and none of the languages were written.

Many of these language groups lack commonly used terminology for many of the issues that we think of and take for granted in health care communications: terms such as allergy, infection, bacteria, anxiety and depression. Explanation of both personal and public health issues with individuals and groups whose language and culture lacks equivalent terminology and beliefs is similarly complex to carrying out these activities in Indian Health - native languages here in the United States, languages such as Navajo and Lakota also lacked these terms and therefore, the historical development of the beliefs and theories connected with them. As you are aware, these are also issues in English speaking minorities where conceptual frameworks for mainstream ideas about prevention and care are poorly understood. The problem is magnified by cultural boundaries and by the lack of equivalent terminology and beliefs.

In the late 1970's and early 1980's there were shifts within the populations described. We began to see more rural people immigrating, individuals who lacked formal schooling and who did not use written language. In addition, many patients (especially women in the Hill Tribe groups) had to speak a second language (such as Lao) in order to communicate in clinic. During the '80's the demography and complexity of language need changed again. We began to see Haitians, peoples from the Horn of Africa (Oromo, Amharic, Somali, Tigrinia), Russians, a variety of Eastern Europeans, Afghans, Iranians, Arab Americans and so on.

Throughout these years, clinics have continued to serve Asian Pacific Island populations as well as a large Spanish speaking community. Geographic differences abound; for example, the clinics at Boston City Hospital and community clinics in the Northeast see large numbers of peoples who speak Cape Verdian Creole. During a recent outreach effort from our Seattle project, we attempted to reach 22 communities targeted by language, ethnicity or geographic location. Over 1400 individuals were interviewed and since we included large groups (such as Arab Americans) we found 33 languages identified as first language or language of choice! I point out this effort only to illustrate the complexity of language and ethnic issues in health care as well as social and educational services. These groups are lost/hidden in our national statistics under terms like "other" when we view or report on issues such as public health, education and the like. The designation of "other" distresses subgroups such as Spanish-speaking migrant workers who may be counted if a designation such as "Hispanic" is used, but who see themselves and who are seen by health providers as a population with special needs.

Many clinics and hospitals - often public institutions - are heavily impacted by specific language groups. The 1,336,957 individuals who were reported to have entered the US as refugees between 1980-92⁵ have often settled in enclaves and this has had a heavy impact on clinic and

⁵ Refugee Reports, March, 31, 1992, pp. 8-13.

hospital facilities many of whom were already burdened by the need to provide language services to large, non-English speaking populations. There is evidence that many institutions (institutions who receive federal funds) have avoided delivery of care to impoverished, limited English speaking, or marginally-covered groups of patients simply by the lack of language facilities or of bilingual staff. This failure to share the work load has placed a disproportionate fiscal burden on other institutions.

Institutions vary in their arrangements to meet the needs of limited English speaking and patients and monolingual health care providers. Even when there is a well defined need, many facilities have not dealt with language and cultural problems in a formal or effective operational sense. This was true when I visited multiple facilities on the West Coast in 1979 and 1980 as West Coast Coordinator for Refugees for the Health Services Administration⁶ and it is true today in major cities with large and diverse ethnic enclaves, cities such as Chicago⁷ or New York⁸.

Formally organized, on-site interpreter programs are often the exception rather than the rule. In general one can state that many hospitals lack a) organized, on-site interpreter services, b) programs to assess and upgrade the skills of bilingual health workers used as interpreters or of the interpreters themselves, and c) programs to train monolingual health care providers in the complexities of cross-cultural, triadic interviewing and negotiation. Providing interpreters is not seen as an institutional responsibility. For example, Chinese-American patients have been turned away for failure to bring an interpreter to the clinic in some California medical centers.⁹ In 1993, similar concerns were expressed by a Chicago area health administrator. He is quoted as saying: "Are we redirecting current money from direct care to interpreter services? No. Our preference is to reduce morbidity and mortality."¹⁰ It is unclear how these goals could possibly be achieved in the absence of adequate communication.

During the 1970s, community-initiated legal actions through the Office of Civil Rights addressed the issues of language, including sign language. These actions were based on Title VI of the Civil Rights Act of 1964, as well as Section 504 of the Rehabilitation Act of 1973. Institutions have responded by developing interpreter programs, by supporting community-sponsored interpreter pools, and by adding bilingual staff in clinic areas serving many non-English-speaking patients. Many of these systems grew out of OCR complaints and settlements.

More than one system that I am aware of is currently engaged in litigation or considering OCR complaints to deal with language issues. There is a distinct need to increase the availability of bilingual health workers, to redefine their skills, and to reconsider some of the curricula that are being used to prepare bilingual interpreters in health care. Too often, these curricula have failed to take into account the special quality and character of interpretation in health care. Engrafting those principles used in court interpretation, or in international/business interpretation fails to take many of the special qualities of medical environments into account. Some of these special issues include; trust, continuity, as well as the need for mental health interpretation and assessment skills. Since the majority of psycho-social disruptions occur in primary care and non-mental health settings, these skills are necessary in all medical environments. In addition, training programs must consider the multiple, shared roles of provider, ombudsman, and culture-broker that medical interpreters are constantly called upon to provide.

⁶ Putsch RW: Cross-cultural communications: The special case of interpreters in health care. JAMA 1985;254:3344-3348.

⁷ Richman, R: Failure to Communicate, The Chicago Reporter 1993;22;1-11

⁸ Newsletter: New York Task Force on Immigrant Health, Spring, 1993.

⁹ Gould-Martin K, Ng C: Chinese Americans, In Harwood A (Ed): *Ethnicity and Medical Care*. Cambridge, MA, Harvard University Press, 1981, pp. 130-171.

¹⁰ Richman, R: Failure to Communicate, The Chicago Reporter 1993;22;1-11.

Language plays a major role in health care access and in preventive health care. This added to the fact that interpreters in medicine share the responsibility for negotiation of difficult patient care decisions represents a potential "headache" to many medical administrators. They want to know: "Who's going to pay for it?" There has been limited work¹¹ done to date that suggests that health care with trained interpreters is more cost effective. The implications of further medical-legal actions in this area, of failures in basic delivery systems, and of demands created by ongoing shifts in immigration policy are all areas that have major impacts on health care delivery systems, especially those that are marginally funded. Issues of language and communication must be thoroughly represented in the process of health care financing and planning. We need to remember three things:

1) In the absence of adequate language services, health care access is severely limited and, furthermore, patients are at greater risk. 2) We are required to provide language services¹² in health care and 3) There is no source of funding for these services short of including them in any health care financing package as services that are required rather than optional.

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Seattle, Washington 98144

¹¹ Hardt, E and Cashman, R (Boston City Hospital): Personal communication, 1993.

¹² "A frequent cause of discrimination on the basis of national origin in health care settings which often leads to violation of Title VI (of the Civil Rights Act of 1964) is the use of ineffective methods of communication between English-speaking health care providers and persons who ... have limited proficiency in English ... Using an interpreter whose skill level is unknown to the provider or who is unqualified (often the case in using family members or friends to interpret), is usually acceptable only in those situations where accuracy and objectivity are not essential." Office of Civil Rights- Region X, US Department of Health and Human Services, Revised, February, 1985.

STATEMENT OF LAWRENCE HILL

Mr. WAXMAN. Dr. Hill?

Mr. HILL. Thank you. Mr. Chairman, as was mentioned, I am the Dental Program Director of the Cincinnati Ohio Department of Health and I am President of the Association of Community Dental Programs.

Personally I have been involved in dental public health programs for the past 20 years, and I am here today on behalf of the Coalition for Oral Health.

The coalition is pleased that the administration's plan would provide dental care for children from the outset, but we are very concerned that most adult care would not be mandated until the year 2001.

Our coalition urges you today to include dental care for both children and adults from the outset in a modest and cost-effective health benefits package.

Dental diseases are not cosmetic problems. When not treated, they can cause pain, disfigurement, malnutrition, and even death. Oral cancer, for example, is more common than leukemia, it is more common than cancers of the brain, the liver, bone, stomach, cervix, and ovaries. If detected early, it is over the 10 percent curable.

But because so many people do not have an opportunity to get routine dental examinations, most oral cancer is already advanced by the time it is diagnosed. For that reason, oral cancer kills more people each year than cervical cancer and costs society over \$2 billion a year in treatment and lost wages.

Dental care, just like the treatment of infections anywhere else in the body, affects overall health. It is critical for diabetics, persons with blood disorders, renal transplant patients, patients on chemotherapy and patients on radiation therapy. Thirty percent of the initial signs of HIV infection are found in the mouth, so it is the dentist who is often the first to diagnose this disease.

Yet over 150 million Americans have no dental insurance. Low income adults who have no access to dental care often must rely on hospital emergency rooms for care. One Cleveland metropolitan hospital experienced a doubling of dental emergency visits from 1,800 to 3,600 annually when dental benefits in a State-wide public assistance program were eliminated.

It is not unusual for a single untreated dental infection to necessitate an 8-day hospital stay at a cost of in excess of \$7,000. Emergency room care is much more costly than simply providing basic adult dental benefits. Delayed treatment too often becomes life threatening. One Los Angeles hospital reports that treating—reports treating many patients who require several days hospitalization for severe oral infections that result in fever and in swelling of the neck, it can actually impair someone's ability to breath.

This is solely due to neglect of oral problems that could have been solved earlier by providing simple, routine fillings, extraction of teeth or similar basic treatment. Tragically, some patients delay care too long and the spreading infection can cause a variety of complications, including severe brain damage or again, even death.

Parents must be eligible for dental care if their children are to be assured access. You simply can't slam the door in mom's face

and tell her that dental care isn't important and expect her to bring her kids to the dentist. We know that in Medicaid, a program that has very much underserved adults, that in any given year 80 percent of Medicaid children never see the inside of a dental office.

In Cincinnati when our local health department had a dental treatment program for children only, the program was underutilized. When we expanded it to include adults, we became inundated with both adults and children. Today that one clinic now has a growing waiting list that approaches 1,000 people.

Dental care is of great concern for the working poor who struggle to get care in our current system. Not long ago, I personally saw a recently unemployed patient who lived outside of our jurisdiction and faced a difficult dilemma. Public assistance health coverage would not—would only reimburse for an extraction to relieve his excruciatingly painful toothache.

However, he realized that a potential job offer would not materialize if he interviewed with a missing front tooth. So he delayed treatment. He lost 10 pounds in about 14 days. We finally managed to bend our rules so he could get the proper treatment but today no county in Ohio covers adult dental care under that assistance program and though this patient got his job, we are forced to turn down others weekly in similar situations.

According to a recent study, employees rank dental care as the second most important benefit after medical plans. Another recent study of AIDS patients found a higher need for dental care than any other service. Dentistry has led the health professions in the development of effective preventive procedures and we know that when only 6 million people had dental coverage back in the 1970's and most visited the dentist for major dental treatment only, whereas today many of those with dental coverage seldom need more than a low cost cleaning or filling because they had regular preventive care.

On behalf of those of us who struggle daily to find solutions for the 150 million people without dental coverage, we urge you today to place primary importance on dental health by including a minimum decency package of dental health benefits for both children and adults from the outset in health care reform legislation.

Thank you.

Mr. WAXMAN. Thank you, Dr. Hill.

[Testimony resumes on p. 307.]

[The prepared statement of Dr. Hill follows:]

STATEMENT OF COALITION FOR ORAL HEALTH

INTRODUCTION

The Coalition for Oral Health is a growing organization that recognizes the importance of oral health as an integral component of overall health and is committed to obtaining access to oral health for all. Members of the Coalition, representing over 150,000 people nationwide, include: a consumer's alliance; public health professionals; dental educators and researchers; African-American, Hispanic, and other dental providers; representatives of community and migrant health centers; and the dental industry. We are not aware that such a diverse alliance has ever come before Congress in support of the oral health of the public. A description of the organizations supporting this statement is attached.

The Coalition supports the universal availability of health services for all U.S. residents and is grateful that the Clinton Administration has recognized the importance of oral health by including a basic package of dental benefits for children and emergency dental care for adults from the outset in its proposed Health Security Act. Inherent in the President's plan is the fact that the mouth is part of the body and that oral health is integral to general health. As stated by former U.S. Surgeon General Dr. C. Everett Koop: "You're not healthy without oral health."

The Coalition believes that everyone should be entitled to at least the modest package of dental benefits essential to diagnose disease, relieve pain, treat infection, and provide proven preventive services. We urge the Subcommittee to create a benefits package that covers treatment of infections -- whether in the foot, the stomach, the arm, or the mouth -- for both children and adults.

The Coalition recommends a basic benefit package that includes diagnosis, emergency care, prevention, and primary care -- a benefit package both humane and cost-effective. We want to assure people with special needs that they will be provided the services they require to be able to function. The basic but essential oral health services we advocate have been described as a "minimum decency package".

**THE CASE FOR IMMEDIATE INCLUSION OF A MODEST ADULT
DENTAL BENEFIT PACKAGE**

Health care reform has been driven by a number of factors, including the lack of access for the 37 million individuals without medical insurance. Our focus is the 150 million people without dental insurance, who are left vulnerable to the hidden epidemic of oral diseases and their adverse impacts on overall health.

While the Coalition is pleased that the Administration's plan includes emergency oral health care for adults immediately and phases in preventive and basic restorative services by the year 2001, we believe that the benefit package must be broadened to include preventive and primary care for adults from the plan's initiation.

Dental diseases are not just cosmetic problems. Dental caries and periodontal diseases are bacterial infections which, like pneumonia and other bacterial diseases, require treatment. Oral cancer is more common than most people realize and kills more people each year than cervical cancer. Untreated dental diseases cause millions of hours of lost productivity and impede employability. Oral health affects general health and treatment of dental diseases is often a medical necessity.

For adults without dental coverage or the means to pay for care, there is no dental "safety net". As in medicine, the hospital emergency room is often the primary source of oral health care for the poor. Not only is this the most expensive way to provide care, but too often the care required would not have been necessary if the patient could have had access to preventive and early interventive oral health care. Moreover, unless there is a dentist available, patients with dental problems will be given only temporary relief – the underlying problem, still untreated, will resurface at a later time. In reviewing hospital admission rates for groups of dental procedures, we see the even more costly results of lack of access and coverage among low income patients. When admission rates were reviewed for dental conditions, major differences were found in hospital admission rates for dental conditions between low and high income areas. In New York City, for example, low income areas have admission rates for dental groupings that are 2.7 times higher than high income areas. In a study of ten states (California, Florida, Illinois, Massachusetts, New Hampshire, New Jersey, New York, Oregon, Washington, and Vermont), low income areas had admission rates that were about 2.4 times higher.

One hospital in Cleveland had 1800 dental emergency room visits annually until dental benefits in the general assistance program were eliminated; this doubled the number of emergency room dental visits to 3600 annually.

A teaching hospital in Texas has over 550 emergency room visits per month for dental pain and infection. University officials estimate a cost of at least \$100 per visit for these patients – or over one half million dollars annually in emergency room costs. A hospital in North Carolina indicates that between five and eight percent of its emergency room visits are for dental care, which, combined with emergency patients seen at the hospital dental program, totals over 625 emergency dental visits per month. Similarly, a New York City hospital dental program reports 860 emergency room dental visits per month. An example of the costs associated with pattern of care is the patient with an untreated dental abscess who required hospitalization for 8 days in New York City at a cost of \$7,000.

The access problems that lead patients to turn to emergency rooms for their care occur throughout the U.S. In Rhode Island, the state health department receives approximately 10 calls each day from residents in desperate need of emergency dental care. After having exhausted the phone book listings of dentists, these people are referred to one of 3 community health center programs, where they are placed on a waiting list of from 3 to 18 months.

Adult oral health also affects employability and self-esteem, as highlighted in the state of Maryland's "Project Independence" program. This is a job training program for welfare

recipients, and is mandatory for those with children over age 3. The state's Secretary of Economic and Employment Development noticed that program participants he met held their hands to their mouths and seldom smiled; they were embarrassed by their decayed teeth. A typical client had many lost and broken teeth and teeth riddled with cavities; treatment of this dental disease helped her to get a job. A state partnership with the University of Maryland at Baltimore Dental School allows participants to receive dental treatment at \$10 a visit. The program has demonstrated the connection between oral health, self-esteem, and employability.

Oral cancer is more common than cancer of the cervix and ovaries as well as leukemia, melanoma of the skin, Hodgkin's disease, and cancers of the brain, liver, bone, thyroid gland, and stomach. While over 90% of oral cancers can be cured if detected early, most oral cancer is "late stage" before it is detected. Each year approximately 30,000 people are diagnosed with oral cancer, and 8,000 people die from it. Many of those who survive require extensive and costly treatment including surgery, chemotherapy, and/or radiation therapy. Treatment costs generally range from \$40,000 to \$100,000 per case and even those who survive have significant disability and lost productivity.

Treatment of oral cancers costs \$1.0 to \$2.3 billion annually. It is estimated that lost wages add an additional \$1 billion or more to the annual cost. Providing oral examinations to prevent oral cancer offers an opportunity to shift costs from those required for treatment to disease prevention. In doing so, it is estimated that 94-98% of oral cancers can be intercepted in the precancerous stage and prevented.

While one wouldn't think of designing a benefit package that didn't include pap smears as a measure to detect and prevent cervical cancer, oral examinations to detect oral cancer are not included in the President's plan until 2001. If regular oral examinations of adults are not covered in the national health care benefit package, many persons would be denied the opportunity to have this life-threatening disease detected early, thus contributing to needless deaths and increasing the chances of disfigurement as the result of extensive surgery that could have been prevented. Dental professionals are trained to detect and diagnose oral cancer. Further, the same oral examinations that are critical for detecting oral cancers can provide early diagnosis of other serious health conditions. Examples include: HIV disease, nutritional disorders, leukemia, diabetes, lymphomas, bulimia, and anorexia.

The Coalition is also concerned about the critical gap in coverage of medically necessary oral health care. Medically necessary oral health care is a direct result of, or has direct impact on, an underlying medical condition. It includes care directed toward control and/or elimination of pain, infection, and reestablishment of function. There are a variety of serious diseases and conditions that can be complicated where oral health is not properly attended to.

- For diabetics, any infection can be life threatening, because the infection exacerbates the diabetes and precludes control of elevated blood sugar levels. In this context, it is important to remember that periodontal diseases and dental caries are the most common infections in adults.

- For those with a blood disorder, gingival (gum) bleeding can be life threatening. Persons at risk include hemophiliacs and those with HIV disease.
- Renal transplant patients, those on chemotherapy, and anyone with an immune deficiency are vulnerable to the uncontrolled progression of the herpes simplex virus (fever blisters). The virus can spread to the brain and spinal cord in those who are immunosuppressed. When uncontrolled, this often results in death.
- For those receiving radiation therapy, a dental abscess or infection frequently becomes uncontrolled and destroys the surrounding bone or even the jaw itself, leading to mutilation and sometimes death. Rampant decay is a common complication due to the destruction of the salivary glands.
- Bacteria from oral infections can similarly spread through the blood stream and attach to heart valves and other prosthetic replacements in patients who have heart murmurs from congenital or acquired heart defects. This results in death 50% of the time.
- For patients on chemotherapy, oral infections can spread unchecked through the blood stream because of the absence of natural defenses. Mouth infections are the most common infections in chemotherapy patients and are therefore a major cause of life threatening disease in these patients.
- Because the earliest manifestations of HIV disease often occur in the mouth, dental professionals play a critically important role in the early detection of this disease. Such early detection means earlier therapeutic intervention is possible, thus extending the productive life spans of affected individuals and improving their quality of life.

Other preventive and primary care services for adults have proven their cost-effectiveness. Topical fluorides can prevent caries (decay) in adults. Periodontal (gum) services can prevent medical complications and foster the establishment of a functional, pain-free dentition which is essential to overall health, proper nutrition, and the prevention of disease. The provision of simple restorations brings significant out-year cost savings for adults by reducing the need for more complicated treatment. According to the National Institute of Dental Research, nearly \$40 billion was saved on dental treatment costs in the 1980s because of improvements in oral health attributable to the widespread use of fluorides, increased use of preventive services by practitioners, and fewer patients needing dentures.

Poor and low income adults with limited or no oral health care coverage do not have access to routine preventive and primary oral care through the existing dental care delivery system. Because Medicaid dental services for adults are optional rather than mandated, some states provide no dental coverage for adults and most of the remainder provide only emergency

treatment or very limited restorative services. More states are considering eliminating adult dental services as the country's economic situation continues to strain state budgets.

The Administration's proposal to cover adult emergency care from the outset is a necessary and important step as it will decrease costs, increase access, and improve quality by giving millions of adults access to dental offices for treatment of dental emergencies. Coverage of emergency care is insufficient, however, because it will not bring about the positive health outcomes that result from the provision of preventive and primary care. A choice to provide adult emergency care only is a choice to forgo the savings from avoiding more costly secondary and tertiary treatment, to forgo the savings from avoiding time away from work and school, and to forgo the financial and individual savings from avoiding pain, disfigurement, and even death.

Dental care is also critical to maintaining the general health of special patient groups of all ages, including those with developmental disabilities, birth defects, genetic disorders and acquired medical disabilities. These people often face catastrophic costs because they require special care just to be able to function. Hospitalization and general anesthesia may be needed to treat children with "nursing bottle caries" cases at a cost of several thousand dollars. Children with facial deformities so severe that they cannot eat, chew, or talk properly need orthodontic care to correct their handicapping malocclusions (bites). Those born with genetic conditions such as ectodermal dysplasias need dentures because they have few or no teeth. Cleft lip/palate patients require surgical intervention and dental appliances to gain function. While we are pleased that the Administration's plan recognizes the need for care for those with genetic disorders, we want to assure all special patients that they not have to worry about "falling through the cracks" -- that payment for their oral health care may be denied because it is classified as "dental" by their medical insurance plan and as "medical" by their dental insurance plan, if any.

CHILDREN'S PRIMARY ORAL HEALTH CARE

The Administration's plan to require the provision of preventive and primary care dental services for children is both scientifically sound and just. This will give all children the opportunity to experience the dramatic improvements in oral health possible with today's proven preventive and restorative techniques. Inclusion of all children is important because dental caries (tooth decay) - the most prevalent of all chronic diseases -- eventually afflicts almost the entire population. Eligibility tiers based on income inevitably leave many vulnerable children just beyond the cut-off and subject to unnecessary disease, pain, and dysfunction.

An example from the Head Start program illustrates the importance of children's oral health care. A Head Start program health coordinator noted a child in the program who was not socializing with other children, did not seem to comprehend the teacher's lessons, didn't respond to questions and didn't participate in group activities. In essence, the child was exhibiting anti-social behavior. Coincidentally, this child eventually remained the only one in the program whose parent had not arranged for the required dental exam and follow-up care. When program staff got the child to a pediatric dentist, she discovered advanced decay, multiple abscesses, and

broken-off teeth with sharp edges. The problems were so severe that the child had to be treated under general anesthesia in a local hospital outpatient surgery department. Within one week after treatment, this little boy began to play with the other children. We must consider the potential for diminished capacity to learn and possibly even aberrant social behavior had this child not been able to get necessary dental care.

Requiring that all children have access to primary and preventive oral health services is especially important for disadvantaged children. Among school aged children, poor, minority, handicapped, and other underserved children experience most of the decay—the very children whose access to oral health services is most restricted because of their families' income, ethnicity, or disabling conditions. Unfortunately, the Medicaid program has been an empty promise for these children. Despite the fact that dental benefits are federally mandated for children through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, fully 80 percent of Medicaid children fail to receive any dental services in a given year.

There is some early evidence that when adults receive dental care, their children are many times more likely to receive care than are children whose parents do not receive care. This is borne out in the experience of Coalition members and is yet another reason why the Coalition believes that the best public policy is to assure universal access to basic benefits for children and adults, stressing prevention and primary care.

THE IMPORTANCE OF PREVENTION AND DENTAL INSURANCE

We are pleased that Congress and the Administration are committed to designing a plan that moves us toward prevention and away from costly treatments. Dentistry is the classic public health success story, having led the health professions by developing a formidable, extensive, well-researched, and cost-effective set of preventive procedures. Unlike many medical conditions that are self-limiting (colds, flu, etc. which run their course without the necessity of a medical intervention), untreated oral diseases typically become more serious, more difficult, and more expensive to treat. The consequences of not treating oral disease extend well beyond the more obvious health consequences such as the severe pain of toothache (which has been characterized as one of the most excruciating types of pain) and inability to chew food, to the more serious general health consequences of severe systemic infections, psychosocial problems, impaired nutrition and weight loss, severe disfigurement, and death. In nearly every case of oral disease, early detection and treatment saves emotional, physical, and financial costs. Every dollar invested in a simple filling saves at least \$8 in the more expensive restorative care that would be required if the problem were left untreated.

In fact, dental care is one of the success stories in the health industry in the past 20 years. In 1970, when only 6 million Americans had dental benefit coverage, most visited the dentist only when they needed major treatment — a root canal, crown, tooth extraction or gum surgery. Today, many of those with dental coverage seldom need treatment more complicated than a

simple cleaning or filling because they visit dental professionals regularly for routine care. Even those who require more complicated treatment require far less than in the past.

So effective is preventive dentistry that dental insurance plans often include incentives to encourage beneficiaries to receive examinations, cleanings, and fluoride treatments. Dental insurance usually provides 100% reimbursement for preventive services, while requiring copayments for restorative services.

Despite the fact that people better understand the importance of prevention, having dental coverage is still the single highest predictor of whether a person obtains oral health care. People with dental benefits are almost twice as likely to visit a dental office in any given year as those without benefits. Almost 50% of those without coverage failed to visit a dental office last year, many delaying treatment until a condition had progressed to an acute or irreversible stage. That is why the Coalition also supports the continuation of the favorable tax treatment for dental insurance plans. We fear that the current dental access problem would be greatly exacerbated if dental coverage was taxable to employees or not fully deductible to employers.

CONCLUSION

The public recognizes the importance of dental care. In Oregon, where inclusion of services under their Medicaid waiver was based on cost effectiveness and consumer input, all dental services except for implants and treatment of temporomandibular joint disorders will be funded for all age groups. A recent study of 857 AIDS patients who were clients of the Robert Wood Johnson Foundation's AIDS Health Services program in 9 U.S. cities found that more respondents reported a need for dental care than for any other service need. Hewitt Associates testified before the Subcommittee on Health of the House Ways and Means Committee that "most employees with major employers now get dental benefits as part of their health plans and that the employees highly value such plans. If a uniform plan design were to cause them to lose access to those benefits, negative employee reaction would be considerable." According to the Hewitt Associates testimony, dental plans rank second only to medical plans in employee attitude surveys concerning preferred benefits; dental plans rank ahead of paid time off, ahead of pension benefits, and ahead of life insurance.

We believe strongly that a basic package of preventive and primary health care benefits, including comparable oral health benefits, should be required to be available in both private and community-based settings to all persons.

Our recommended oral health benefit package is detailed on the following pages. In general, the benefit package the Coalition recommends is intended to incorporate basic diagnostic, preventive, and treatment services that have been proven effective in preventing and controlling dental and oral diseases and defects. We are recommending some of the least costly and most cost-effective health services available.

**COALITION-ENDORSED ORAL HEALTH CARE
"BASIC" COVERED BENEFITS**

The Coalition for Oral Health proposes that the following basic benefit package be mandated as part of the required health care benefit package for children and adults:

1. Preventive Services
 - A. Professional Oral Health Assessment. A thorough annual examination of hard and soft tissues of the oral cavity and related structures, including necessary radiographs and counseling.
 - B. Dental Sealants. The chewing surfaces of permanent molar teeth are those that are most susceptible to tooth decay. Dental sealants, plastic coatings applied on these surfaces, offer the greatest protection against this decay.
 - C. Professionally-Applied Topical Fluoride. Topical fluoride application for children and adults who are assessed to be at high risk for dental caries.
 - D. Oral Prophylaxis. An annual dental cleaning.
 - E. Fluoride Supplements. This preventive prescription would be available for children up to age 13 in areas where the fluoride level of the community's water supply is less than optimum.
 - F. Space maintenance for children 3-12 years of age. This procedure prevents orthodontic complications for permanent molar teeth that would be prevented from normal eruption if the space were not maintained.
2. Acute, Emergency Dental Services. Coverage includes services which eliminate acute infection, control bleeding, relieve pain, and treat injuries to the maxillofacial region.
3. Early Intervention Services (to maintain and restore function)
 - A. Restorative Services. Dental fillings with FDA-approved materials, excluding metal castings and cosmetic services.
 - B. Endodontic Services (root canals) for those up to age 18.
 - C. Periodontal Maintenance Services. Basic, non-surgical periodontal (gum) therapy, beyond tooth cleaning and polishing, for those 15 years and older.

4. **Special Needs Patients.** Special needs patients include, but are not limited to, those with developmental disabilities, regardless of age (e.g. birth defects such as cleft lip/palate and genetic disorders such as ectodermal dysplasia and Sjögren's Syndrome), and acquired medical disabilities from either traumatic, neoplastic, or infectious disease (e.g., tuberculosis, HIV, oral cancer). The benefit package includes those services required to assure special needs patients the above package of basic oral care and additional services they require to have a functional dentition, including, when necessary, hospitalization and general anesthesia, orthodontic care for handicapping malocclusions, and appropriate prosthodontic care for those with ectodermal dysplasia and other genetic disorders.
5. **Dentures.** Removable prosthodontics to restore function are included, using a phased-in approach. Initially, full dentures are covered, limited to no more than one set every 8 years, except for special needs patients. Partial dentures would be phased in as rapidly as the system would allow.

Fundamental to our proposal is that any medically adjunctive oral health care is covered. Also inherent in the proposal is recognition that, if a dentist is licensed to provide a covered service in the health plan, then the dentist should be allowed to provide those services and be reimbursed in the same manner as any other provider in the plan. In addition, health plans should not discriminate in participation or reimbursement against providers who are licensed to perform services and are practicing within the scope of their license.

While the oral health of many thousands of citizens would benefit from the provision of other dental procedures (e.g., crowns, bridges, and removable partial dentures), this benefit package, in the interest of containing cost, allows for only the most basic of dental services. The premium (which has been adjusted to reflect 1994 fee schedules) for this preventive and primary oral health package for children and adults would cost less than \$10 per month.

COALITION FOR ORAL HEALTH MEMBERS SUPPORTING THIS STATEMENT

AMERICAN ACADEMY OF ORAL MEDICINE was established to combine the knowledge and skills of dentistry and medicine to promote total health care. Members' practices are involved with the diagnosis and treatment of diseases which primarily and secondarily affect the oral cavity and its adjacent structures and care of the medically compromised.

AMERICAN ACADEMY OF ORAL PATHOLOGY represents the specialty of dentistry that provides clinical and laboratory services to private practitioners, institutional and hospital dentists, physicians, and pathologists. Their services are critical for development of a primary health care program that emphasizes early detection and prevention of cancer, the oral management of AIDS patients, and the early detection and management of transmissible infectious diseases.

AMERICAN ASSOCIATION FOR DENTAL RESEARCH represents over 4,500 professionals involved in oral health research throughout the United States. The Association promotes research to improve oral health worldwide and fosters dissemination of scientific advances relevant to oral health. The association facilitates communication, collaboration, and research training and education within the scientific community. The AADR is a Division of the International Association for Dental Research.

AMERICAN ASSOCIATION OF DENTAL SCHOOLS represents all of the dental schools in the United States, as well as advanced education, hospital, and allied dental education institutions. It is within these institutions that future practitioners, educators, and researchers are trained; significant dental care provided; and the majority of dental research conducted.

AMERICAN ASSOCIATION OF ORAL AND MAXILLOFACIAL SURGEONS represents the 6,000 oral and maxillofacial surgeons in private and academic practice and whose members provide to patients extensive office and hospital based oral and maxillofacial surgical care.

AMERICAN ASSOCIATION OF PUBLIC HEALTH DENTISTRY represents the specialty of dental public health. It has a diverse membership of oral health professionals. AAPHD's primary focus is to improve the oral health of the public, using principles and methods of public health practice.

AMERICAN DENTAL HYGIENISTS' ASSOCIATION is the largest national organization representing the professional interests of approximately 100,000 licensed dental hygienists across the country. To improve the public's total health, the mission of the ADHA is to advance the art and science of dental hygiene by increasing the awareness to and ensuring access to quality oral health care, promoting the highest standards of dental hygiene education, licensure and practice, and representing and promoting the interests of dental hygienists.

AMERICAN DENTAL TRADE ASSOCIATION founded in 1882, represents Dental Distributors; the Dental Laboratory Conference (leading Dental Laboratories) and dental manufacturers. The objectives of ADTA are to promote and encourage the development, production, and distribution of equipment and materials for the dental profession, dental schools, and dental laboratories so as to enable its members to perform the highest degree of useful service for the public.

AMERICAN PUBLIC HEALTH ASSOCIATION represents 32,000 formal and 20,000 affiliate members in all disciplines of public health. The Association promotes and protects personal and environmental health.

AMERICAN SOCIETY OF DENTISTRY FOR CHILDREN is the oldest advocacy group within dentistry for promotion of oral health for the children in the United States. Its distinguished history goes back to the middle 1920s and it remains today a coalition of specialists of pediatric dentistry who deeply believe that the dental professions must always focus on preventive dentistry for the child patient population and for the reclamation of dental health for dentally diseased children.

ASSOCIATION OF COMMUNITY DENTAL PROGRAMS is an organization comprised of dental directors and dental program personnel of local and county health departments and staff of any other community based dental public health programs. The mission is to assure access to dental prevention and treatment services to all constituents in a cost effective manner by minimizing duplication and sharing information and methods.

ASSOCIATION OF MINORITY HEALTH PROFESSIONS SCHOOLS is an organization which represents eleven Historically Black Health Professions Schools in the country. The primary focus of the association is to seek the improvement of the health status of minority communities.

ASSOCIATION OF STATE AND TERRITORIAL DENTAL DIRECTORS is a voluntary professional organization whose members are the directors of public oral health programs in the states and U.S. territories. ASTDD is an affiliate of the Association of State and Territorial Health Officials.

CLINICAL DIRECTORS NETWORK, REGION II, INC. is a peer organization providing collegial support, networking, education, and research opportunities for primary care clinicians practicing in Community Health Centers.

FEDERATION OF SPECIAL CARE ORGANIZATIONS IN DENTISTRY is an umbrella organization for the American Association of Hospital Dentists, Academy of Dentistry for the Handicapped, and the American Society for Geriatric Dentistry. The federation joins together organizations of like missions to stimulate teaching, education, research, and patient care for special populations including the mentally and physically challenged, medically compromised, and the elderly and frail.

HISPANIC DENTAL ASSOCIATION was founded in January 1990 and currently represents 642 members. The mission of HDA is to provide leadership and represent professionals who share a common commitment to improve the oral health of the Hispanic community.

KENTUCKY ORAL HEALTH CONSORTIUM, INC. is an organization promoting awareness of the effects of dental disease on the health of all Kentuckians, stimulating oral health program development, and fostering pilot projects that support or promote the prevention of dental disease and improved access to oral health services.

NATIONAL ALLIANCE FOR ORAL HEALTH is a coalition addressing the oral health needs of special patient populations. NAOH is a non-profit coalition of voluntary health groups, professional health-related organizations, and individuals who are united by their common concerns for the needs of special patient populations.

NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS represents 560 organizational members. NACHC has aided and overseen the growth and development of community and migrant health centers and worked to bring health center administrators and clinicians together with consumers on the state level to aid them in development of their own advocacy network.

NATIONAL DENTAL ASSOCIATION represents ethnic minority dentists and allied dental professionals in the United States and the communities they serve. Their mission is to improve the oral health status of the medically underserved and disenfranchised by increasing the number of minority providers, researchers, and educators.

NATIONAL NETWORK FOR ORAL HEALTH ACCESS is an organization of dental providers practicing in community, migrant, and homeless health centers with the goal of improving the health status of the unserved and underserved through improved and increased access to oral health care.

Mr. WAXMAN. Dr. Parkinson.

STATEMENT OF MICHAEL D. PARKINSON

Mr. PARKINSON. Good afternoon, Mr. Chairman, Mr. Brown. I want to express my personal gratitude for the invitation to appear before you today to discuss what we consider to be a real watershed event in the history of preventive medicine and public health, that is the inclusion of clinical preventive services in a basic benefits package.

I would like to highlight some of our thoughts as the medical specialties society most concerned with preventive medicine and public health about the preventive services themselves and to highlight some of our concerns, which will echo those of yours this morning, Mr. Chairman, concerning funding mechanisms for what we consider to be the foundation of clinical preventive services, and that is population based approaches to prevention.

The overall comprehensiveness, scope, and the thought that went into the prevention elements of the Health Security Act are indeed commendable. As a group, we think that they address practically every component of the prevention venue that we deal with. We are particularly impressed with the use of epidemiologic methods, a scientific approach in the plan to get involved in areas such as quality assurance and quality management, areas which are long overdue in our health care delivery system.

Let me explain a little bit about the specialty of preventive medicine and why in my subsequent review of clinical representative services we may highlight some areas that other specialty groups might not have.

Preventive medicine as a specialty has been around for about 40 years and is unique among other medical specialties in that physicians are trained in both clinical medicine and in public health, that is a population approach to the health of individuals and communities.

Our physicians practice in a wide variety of settings that combine both individual medicine and population approaches to health: Public health agencies, occupational health settings, hospitals, clinics, government agencies, et cetera.

In preventive medicine, we consistently however rely on a quantitative and epidemiologic approach on what we do and how we decide what we are going to do. In that regard, we are particularly struck and pleased that the clinical preventive services covered in the President's plan are based largely upon the U.S. Preventive Services Task Force recommendations of 1989 which used a rigorous scientific quantitative method to determine what is or is not effective.

It specifically was not done by, quote, "best opinions" about what should or should not be covered. We think that methodological approach should be commended and extended throughout the entire plan, as it has been. We caution that the science of preventive medicine is based in diagnostic and therapeutic changes.

You might have read about a new gene to detect people at high risk for colon cancer, combined immunization schedules, flexible sigmoidoscopy that might be effective in decreasing colon cancer.

All of these moving targets are difficult to incorporate in a piece of static legislation.

Therefore, we would suggest that perhaps the committee consider deleting some of the provisions in the recommended period and frequency, because it turns out the science on the frequency of an examination or a screening of examination, or a periodic health examination is less solid, if you will, than the absolute data that should or should not be done in the first place.

We are concerned that we don't want to make the process of changing the recommendations to be scientifically inappropriate, too rigid, and perhaps we should handle that administratively rather than legislatively.

The National Health Board appears to have that authority, but we would like to see perhaps a little less language around the frequency and maybe even the age cut-points for some of the interventions that are recommended.

We particularly commend once again the Clinton health plan for its reliance on the knowledge that much of what physicians and other health care providers do in their offices is probably misdirected and should be redirected towards health education, changing behavior.

And that is why the notion of a periodic health visit where you assess risks and target your intervention to those risks is absolutely appropriate, moving away from the, quote, "complete physical" perhaps of the 1950's and 1960's.

The other element which is absolutely critical, as Dr. Feder referred to, is the absence of co-payer deductibility. They do decrease utilization and in preventive services, we cannot afford a decrease in utilization. Even after we pay for preventive services, we know they are not utilized.

That gets us to the area that we talk about next, that is the enabling services: Getting to high risk women who need prenatal care, getting individuals who need immunizations. That will not come about because we give them a card that enfranchises them to health services benefits.

We are very concerned, as other speakers have said, that the appropriations and budget process for the public health infrastructure for things such as enabling services and indeed for research into disease prevention, health promotion, and for such things as health outcomes, research into the area of prevention is indeed dependent upon discretionary caps.

And without the science moving forward, without the services moving forward, it is doubtful in my mind and those of physicians who practice in this area that we will see significant increases in utilization in those interventions found to be scientifically efficacious in reducing health care costs, in reducing indirect costs in our society.

So Mr. Chairman, members of the committee, once again, thank you for being here, thank you for your leadership over the years in this most important area.

Mr. WAXMAN. Thank you for your testimony.

[The prepared statement of Mr. Parkinson follows:]

STATEMENT OF AMERICAN COLLEGE OF PREVENTIVE MEDICINE

Mr. Chairman and members of the Subcommittee, my name is Michael D. Parkinson, MD, MPH. I serve on the Board of Regents of the American College of Preventive Medicine as the regent representing general preventive medicine. On behalf of the American College of Preventive Medicine, I am honored to have the opportunity to discuss the Health Security Act with you today. I will focus on the preventive services in the benefit package, but I will also explain our view that, while preventive benefits are absolutely necessary to prevent disease and improve the health of Americans, there is also much more that can be done.

Prevention in the Health Security Act

The College has endorsed wholeheartedly the comprehensive strategy for prevention incorporated in the President's health plan. The plan recognizes that successful disease prevention and health promotion must address the health of both individuals and communities. It provides for universal coverage of clinical preventive services that have been shown to be effective in preventing disease and prolonging life. At the same time, the plan acknowledges the pressing need to strengthen the public health infrastructure that provides population-based services. These are services that transcend the boundaries of any individual health provider or facility, such as community-wide disease surveillance, health status assessment, outreach, and health education.

The plan also addresses other aspects of the health system essential to our nation's progress in prevention. These include: building a system of quality management that emphasizes measurement of performance and provision of information to consumers; a new system of funding graduate medical education that will respond unequivocally to our need for more

physicians trained in primary health care and prevention; and increased emphasis on prevention research to provide a better scientific basis for our efforts.

Taken together, all these aspects of the Health Security Act constitute an approach to prevention that is uniquely comprehensive in scope and long overdue. As next year's challenging debate on methods and costs of achieving universal access to health care unfolds, we urge you not to let these issues "slip through the cracks." They are all essential to improving the health of our population.

Preventive Medicine

I would like to describe briefly for you the specialty of preventive medicine, because it will help to explain our approach to evaluating the clinical preventive services that would be covered under the Health Security Act. Ours is a small specialty, but it has been recognized for over 40 years by the American Board of Medical Specialties.

Prevention, in its broadest sense, is practiced by all physicians and other health professionals who help their patients stay healthy. However, the specialty of preventive medicine is unique in its dual emphasis on clinical medicine and public health. Specialists in preventive medicine have learned how to diagnose and treat the health problems of communities, as well as those of individuals. The distinctive aspects of preventive medicine include knowledge and competence in such disciplines as epidemiology, biostatistics, occupational and environmental health, the social and behavioral aspects of health and disease, and the planning and evaluation of health services. Preventive medicine specialists work in a wide variety of settings, including public health and other community or government agencies, the workplace, primary health care

settings, and academia.

Clinical Preventive Services in the Health Security Act

In preventive medicine, we use scientific, quantitative analysis to develop and evaluate preventive interventions. One great strength of the proposed clinical preventive services benefits is that they have been shown to be effective in preventing disease or death. They closely parallel the recommendations of the United States Preventive Services Task Force, whose work the College endorses. The Task Force uses a rigorous and systematic methodology to evaluate the evidence of effectiveness of preventive services. It recommends only those for which there is evidence of high scientific quality that the service can contribute to improvement of an individual's health and does more good than harm.

Good science should be the principal basis for choosing preventive benefits. It must be recognized, however, that scientific knowledge is always growing and changing and the need to change the benefit package to conform to new knowledge must be anticipated. We have some concern that the specificity of the proposed statute concerning covered clinical preventive services will inhibit future flexibility. We urge the Subcommittee to examine alternatives other than amendment of the law for modification of the clinical preventive services in the benefit package, whether such modification consists of adding services of newly documented effectiveness, or deleting services discredited by future findings.

The National Health Board appears to have discretion to modify age and frequency for covered clinical preventive services. We believe this is appropriate, and would suggest that the Act's detailed specifications for the frequency with which these services may be provided be

omitted. Instead, the National Health Board could be instructed to determine appropriate age ranges and frequencies for covered services in consultation with a broadly representative group of experts. This would be consistent with the role already proposed for the Board of defining additional services for high risk populations and establishing periodicity schedules for them.

A second strong point of the benefits package is the provision for periodic health examinations (termed "clinician visits" in the Act) that include an individual risk assessment and targeted health advice and counseling, as well as a history, physical examination, and age-appropriate immunizations and screening tests. A principal finding of the U.S. Preventive Services Task Force was that preventive interventions that address the personal health habits of individuals are among the most effective interventions available to clinicians for reducing the incidence and severity of the leading causes of death and disability in the United States. Primary prevention that addresses such underlying causes of disease, disability and premature death as smoking, poor nutrition, physical inactivity, alcohol and other drug abuse, sexual behavior, and unsafe use of motor vehicles holds greater promise for improving overall health than many secondary preventive measures such as routine screening for early disease.

Physicians and other health providers who understand these underlying causes and use carefully chosen techniques for counseling and reinforcement can help persons change health behaviors. The periodic health examination is by no means the sole route to achieving behavior change, but it is one important avenue.

Cost Sharing for Preventive Services

The Health Security Act would provide routine clinical preventive services to

asymptomatic individuals free of copayments or deductibles. This is an extraordinarily important provision for encouraging utilization of preventive services. Cost-sharing has a role in inhibiting inappropriate utilization of health services. In the case of effective preventive services, however, the objective of our policy should be to promote utilization; over-utilization is prevented by the limits of the benefit package. It would be counter-productive to establish any financial disincentive for use of preventive services, particularly with respect to higher-risk populations that stand to gain the most from prevention.

Population-Based Prevention

Universal availability of effective clinical preventive services is one strategy for improving the nation's health. Another strategy recognized by the Health Security Act is to renew our emphasis on public health and population-based preventive measures. The greatest advances in improving the health of Americans have been attributable to public health activities such as provision of safe water, sewage disposal, and the control of infectious diseases through immunizations. Now we must use such population-based tools as public education about health and safety, abatement of environmental hazards, and identification and outreach to populations at highest risk to address the current major causes of poor health and premature death -- tobacco use and exposure, substance abuse, poor nutrition and physical inactivity, and such epidemic infectious diseases as HIV infection and tuberculosis.

A population-based approach to prevention is also a way to use our health resources more intelligently. The use of epidemiologic methods to assess the health status and identify and quantify the particular health problems of a community enables a rational and efficient

deployment of resources to address those problems. A community can be defined for these purposes as a state or locality, the population served by a particular health plan or health center, or even as the group of people working for a single large employer. Outreach for the purpose of linking persons in any community at highest risk for disease to preventive services is fundamental to the success of the clinical preventive services in the benefit package in improving that community's health.

The public health initiative in the Health Security Act would support public health functions for states and localities, while the proposed quality management system implicitly requires the use of population-based methods by health plans and providers to achieve better health outcomes. The national health promotion and disease prevention initiative would support cooperative public and private efforts to target population-based prevention activities to the most needy and vulnerable populations.

These are all well-conceived and important aspects of the Health Security Act. We are alarmed, however, by the Act's sole reliance on annual appropriations for most public health and disease prevention activities. In light of the current tight caps on discretionary domestic spending, the public health and prevention initiatives will be an empty promise unless another certain and consistent source of financing is found. Please take to heart our message that successful prevention must address the health of communities, as well as the health of individuals.

Mr. Chairman, please accept our gratitude for your attention today and for your energetic and skillful leadership in prevention and public health. We want to do everything we can to assist the Congress and the President in achieving universal access to health care.

STATEMENT OF L. EDWARD ELLIOTT

Mr. WAXMAN. Dr. Elliott.

Mr. ELLIOTT. Thank you, Mr. Chairman. I am Ed Elliott, a doctor of optometry from Modesto, Calif. and a past president of the American Optometric Association.

On behalf of the Nation's 28,000 optometrists, I commend you for holding this hearing on the important issue of what should go into a benefits package under health care reform and thank you for the opportunity to present our views. You have my written statement.

The AOA applauds the President for putting forth a comprehensive proposal to address the issue of universal access to health care. While we have a number of concerns regarding the administration's plan, we certainly support the concept of a uniform benefit package and agree that eye care must be part of such a package.

We are pleased that the White House has clarified in a memorandum to congressional leaders that the eye care component of the administration benefit package includes routine periodic eye examinations as well as the diagnosis and treatment of vision defects and eyeglasses and contact lenses for children under 18.

We would strongly urge the Congress to set forth a uniform benefit structure and to retain this important benefit as it considers health care reform.

Any benefits package should clearly cover symptom-related visits for acute problems including eye health problems. A model for coverage already exists at the Federal level with the Medicare program. In addition, to assure early diagnosis of potentially costly and debilitating eye and systemic diseases, periodic preventive eye and vision care examinations should also be included in the package.

The long-term saving to the health care system by early diagnosis of costly eye and systemic diseases would more than offset the cost of providing this care. Regular eye examinations are an essential preventive measure for early diagnosis and prompt treatment of eye diseases which, if left undetected, result in serious personal loss and significant societal costs.

A recent study by the Georgetown University Medical Center has concluded that about 250,000 of the new cases of blindness each year are curable and preventable through timely detection and treatment, leading to an estimated annual savings to the Federal budget of over \$1 billion.

Mr. Chairman, it is also significant to note that the health maintenance organization industry has long recognized the cost-effective nature of routine eye care. Data from the 1991 annual HMO study or industry survey conducted by the Group Health Association of America show that more than 90 percent of all HMO's cover routine eye and vision examinations on a periodic basis.

We are pleased to note that the administration proposal embodies this approach to coverage through its health professional services section and its vision care section.

Finally, Mr. Chairman, we would like to express our concern that managed care plans not be allowed to arbitrarily exclude entire classes of providers who are qualified to provide services covered in the benefit package.

While the administration proposal would allow doctors of optometry and other providers to deliver care on a level playing field with their colleagues in medicine in the fee-for-service arena, the same is not true for managed care plans. The administration proposal would preempt State nondiscrimination statutes and allow managed plans to limit the number and type of health care providers who may participate in the plan.

To ensure access to a representative network of providers, it is imperative that any health reform plan contain a strong non-discrimination provision to prevent exclusionary practices based on artificial barriers. In short, provisions prohibiting discrimination should apply equally to fee-for-service and managed care plans.

Mr. Chairman, vision and eye health problems are the second most prevalent health care problems in our Nation, affecting more than 120 million people. We believe a combination of symptom related and preventive eye and vision coverage in a basic benefits package as proposed by the administration makes good sense for the long-term health of our Nation.

Again, I thank you for the opportunity to testify on this important issue and would be happy to answer any questions.

Mr. WAXMAN. Thank you very much.

[The prepared statement of Dr. Elliott follows:]

Testimony of the

AMERICAN OPTOMETRIC ASSOCIATION

Mr. Chairman, my name is Edward Elliott, a doctor of optometry from Modesto, California. I appreciate the opportunity to testify before the Subcommittee, and I commend the Chairman for holding these hearings and also for his leadership in addressing the issue of health care reform.

I am in private practice in Modesto and also teach at the University of California at the Berkeley School of Optometry. I am a past president of the American Optometric Association (AOA) which represents the largest eye care profession in the Nation with approximately 28,000 optometrists in practice. As an organization representing the providers of the majority of primary eye care services in the Nation, we welcome the opportunity to discuss the benefits that should be included in a comprehensive health benefits package.

The AOA applauds the President for putting forth a comprehensive proposal to address the issue of universal access to health care. While we have a number of concerns regarding the Administration's plan, we certainly support the concept of a uniform benefit package, and agree that eye care must be a part of such a package.

We are pleased that the White House has clarified in a memorandum to Congressional leaders that the eye care component of the Administration benefit package includes routine periodic eye examinations as well as the diagnosis and treatment of vision defects, and eyeglasses and contact lenses for children under 18. We would strongly urge the Congress to set forth a uniform benefit structure and to retain this important benefit as it considers health care reform.

NEED FOR EYE CARE

Vision and eye health problems are the second most prevalent, chronic, health care problems in the U.S. population, affecting more than 120 million people. Undetected and untreated, they reduce the educability of the child, hasten the loss of independence in the elderly and contribute to the social isolation of the individual. Early detection and appropriate treatment are essential to preserve performance and prevent damage and consequent handicaps which can result from neglect. The two age groups at highest risk for vision problems are children and the elderly.

Children

Children are at high risk because of the impact of uncorrected vision handicaps on their educational and developmental progress, including visual and perceptual skills for language and learning. Since most vision problems occur without pain, they may be completely unknown to parents, teachers or even the child. The behavioral changes caused by undetected vision problems in children are often erroneously attributed to other unrelated causes, such as attention deficit disorder. Early diagnosis and treatment can aid in preventing or correcting vision conditions which can interfere with a child's learning and self image.

Elderly

The elderly, too, are at risk because of physiological changes which come with age. The elderly develop increasing incidence of systemic disease and a decline of sensory function. Vision and eye health problems increase significantly in frequency and severity with age and are more prevalent in those over 60. With the reduction in vision in the elderly, many times comes an increase in dependency. By providing regular eye care to the elderly, many times an independent life style can be maintained.

Equally important, regular eye examinations are an essential preventive measure for the early diagnosis and prompt treatment of eye diseases, which if left undetected, result in serious personal loss and significant societal costs. A recent study by the Georgetown University Medical Center has concluded that about 250,000 of the new cases of blindness each year are curable or preventable through timely detection and treatment, leading to an estimated annual savings to the federal budget of over \$1 billion.

Mr. Chairman, it is significant to note that the health maintenance organization industry has long recognized the cost-effective nature of routine eye care. Data from the 1991 annual HMO Industry Survey conducted by the Group Health Association of America show that more than 90 percent of all HMO's cover routine eye and vision examinations on a periodic basis.

OPTOMETRY'S ROLE

For many people, an eye examination is the entry point into the health care system since many Americans who postpone or avoid other forms of health care often continue to seek eye care. Over 60 percent of the primary eye care examinations in this country are performed by optometrists. In a typical state, nearly two-thirds of all available eye care specialists are doctors of optometry.

Optometrists are the most accessible of eye care providers, serving in more than 6,800 municipalities throughout the United States. In more than 4,000 of these communities, optometrists are the only primary eye care providers.

While approximately 70 percent of optometrists are in private practice settings, many others practice in multidisciplinary group practices, in hospitals, with the Veterans Administration, Public Health Service, and the Armed Services. Other optometrists participate in managed care plans such as HMOs, preferred provider organizations, and independent practice associations. In many of these organizations optometrists function as the entry point into the system for eye care.

As primary care providers, optometrists are an integral part of the health care team. They are specifically trained to diagnose, manage, and treat conditions and diseases of the human eye and visual system. As an

entry point into the health care system, optometrists are positioned to serve a prevention role as an effective source of triage for not only eye health problems, but systemic health problems with eye manifestations as well.

ACCESSIBILITY

Because of their geographical distribution, optometrists provide services to patients that they may not have access to otherwise. This is especially true in rural areas. In many areas, an optometrist may be the only eye care provider available.

Low income patients, often at high health risk, are very dependent on optometrists for their primary eye care services. In Oregon, a 1991 report found that over two-thirds of the care rendered to this high health risk population was provided by doctors of optometry. Historically, as a profession, optometrists have demonstrated a high participation rate in government programs serving disadvantaged communities.

COST EFFECTIVENESS

Besides being accessible, optometrists are also cost effective. Office fees and charges for visits associated with the treatment of eye diseases are on average lower for an optometrist than an ophthalmologist. National and regional surveys of professional fees and analysis of public health programs present significant evidence of the lower cost of eye care when provided by optometrists.

Managed care entities that utilize optometrists to provide primary eye care services recognize the cost savings such a delivery model can accomplish. InterStudy, a nationally recognized research firm, documented a potential 36 percent savings when optometric manpower was utilized to the full extent of their training and competence. "The most cost effective models are those where optometrists perform all routine examinations and also manage certain eye diseases and conditions," the study concluded.

COMPREHENSIVE EYE CARE BENEFITS PACKAGE

Having described eye care and optometry's role in the health care system, I would like to outline what the American Optometric Association feels should be included in any comprehensive eye care benefits package. A comprehensive benefits package should include two components -- regular periodic preventive care for all age groups, and the more symptom-related diagnostic and treatment services currently covered under the Medicare program. In addition, the package should continue to provide ophthalmic materials for the Medicaid population.

Preventive

To assure early diagnosis of potentially costly and debilitating eye and systemic diseases, preventive eye examinations are recommended as follows:

From birth to six years of age there are three critical periods in which examinations should be given. Every infant should be entitled to an eye/vision examination at 6 months by an eye care practitioner. Every child should be entitled to an eye/vision examination at ages 3 and 5 by an eye care practitioner. It is imperative that every school age child, usually age 5 or 6, receive a full eye exam before entering school to insure that they will be able to function in the classroom.

Children between the ages of 7 and 19 should receive eye examinations every year. Between the ages of 20 and 64 individuals should receive an examination at least every two years. Over the age of 65 the schedule should again be yearly. In addition to this schedule, high risk groups, such as diabetics, should be seen on a more frequent basis. For example, the Centers for Disease Control recommends that all patients with diabetes mellitus should have a yearly eye examination.

Symptom-Related

As part of the second component of the comprehensive benefits package, symptom-related services should be covered. Vision and eye care diagnostic and treatment services currently covered under the Medicare program should be a covered service for all individuals. This would mean that the eye health part of an examination would be covered when the patient had a symptom, condition or complaint that necessitated the visit.

We are pleased to note that the Administration's proposal embodies this approach to coverage through its health professional services section and its vision care section.

NON-DISCRIMINATION BY MANAGED CARE PLANS

Finally, Mr. Chairman, we would like to express our concern that managed care plans not be allowed to arbitrarily exclude entire classes of providers who are qualified to provide services covered in the benefit package. While the Administration proposal would allow doctors of optometry and other providers to deliver care on a level playing field with their colleagues in medicine in the fee for service arena, the same is not true for managed care plans. The Administration proposal would pre-empt state non-discrimination statutes and allow managed plans to limit the number and type of health care providers who may participate in the plan. A preliminary draft of the Administration's proposal had specified that each health plan would be "expected to provide a sufficient mix of providers and specialties to provide adequate access to professional services." However, this concept is not contained in the final Administration bill, and absent strong legislative direction, the

sufficient mix of providers referred to in the draft is not likely to occur. To ensure access to a representative network of providers, it is imperative that any health reform plan contain a strong non-discrimination provision to prevent exclusionary practices based on artificial barriers. At a minimum, there should be criteria for provider eligibility in managed plans reflecting the needs of the plans' enrollees and their rights to choose from a diverse mix of providers of covered services. The volume, capacity and geographic distribution of health care providers within the network area should be considered to ensure appropriate representation. In short, provisions prohibiting discrimination should apply equally to fee for service and managed care plans.

CONCLUSION

Mr. Chairman, AOA strongly supports the concept of universal access to health care and a uniform benefit structure. The Administration plan has rightfully recognized routine preventive eye care as an important component of the benefit package and we would urge the Congress to retain this benefit as it develops a reform plan. At the same time, we would also urge Congress to address the critical issue of non-discrimination by managed care plans to ensure that each plan provides access to an appropriate mix of providers of covered services.

Thank you again for the opportunity to testify on this important issue. I would be happy to respond to any questions.

Mr. WAXMAN. I think each of you is to be commended for the testimony. I think you have given us very good testimony and recommendations, and I know and I hope you know that we are preparing a transcript of this hearing which we will share with all of the members of the subcommittee.

I think it will be helpful for all of us as we think through the way to fashion this legislation.

Mr. Brown, do you have any questions?

Mr. SHERROD BROWN. Yes, I do. Dr. Hill, considering the costs of sooner than the phase-in, the 2001 phase-in, how do you justify when every question—almost every other question on this panel is about costs and how we are going to pay for this, how do you justify phasing in much faster than that or immediate implementation of dental coverage?

Mr. HILL. I guess the issue becomes one of—for me certainly as a practitioner, the issue becomes one of illness, of care.

Oral cancer, as I mentioned, kills more people every year than cancer of the cervix. That means that between 1998 and 2001, 27,000 people will die as a result of oral cancer. And that is a cancer that is 94 to 98 percent curable with early detection.

So you know from my standpoint I guess certainly you know what I would have to ask is in terms of illness is what are 27,000 lives worth?

Another one is in terms of cost when we look at the hospital costs that we are incurring right now, one Texas hospital estimates that they are spending about \$750,000—somewhere between \$500,000 and \$750,000 a year in the treatment of dental emergencies. I mentioned that it costs—it can cost easily \$7,000 for an 8-day visit in a hospital.

There was a case in—two cases, actually, simultaneously in Palm Beach County, Fla., not long ago where two patients were in the hospital as a result of untreated dental infections. One of them was on IV fluids and it is questionable as to whether that patient was going to survive. The other patient was in the hospital for an extended stay, and it was estimated that those two patients, the cost of care for those two patients was going to exceed \$80,000.

You can buy a lot of adult dental care for \$80,000, a lot of adult dental insurance for \$80,000. That was for two patients in one county within a 2-week period.

Mr. SHERROD BROWN. Talk to us, if you would, about the co-pay issue for dental care. Is there a co-pay only for nonpreventive care, for restorative care, or is there co-pay—what is in the plan regarding that?

Mr. HILL. I guess my understanding is that there is a co-pay for services in the plan. I am not sure, you know—I think one of the things we have to look at co-pays, I guess we have to look at this across the board for all services again, is that, you know, co-pays can on one hand help control overutilization, and on the other hand, the other side of the sword is that they can discourage appropriate utilization.

The thing that I would ask in the area of oral health care is that co-pays not be looked at any differently, you know, for oral health care, again, than they are looked at for anything else.

The issue is that these are systemic bodily kinds of infections and the co-pay issue I think again needs to be—needs to be determined across the board and needs to be—it is a difficult one, but I think it needs to be settled on an issue that allows access and controls for overutilization.

Mr. SHERROD BROWN. Have you done any calculations of cost—maybe Dr. Parkinson can answer this more precisely, I guess.

First with you, have you done any calculations of cost on preventive care with dental benefits and what the difference would be between now and 2001?

Mr. HILL. For one, we know that in the 1980's the National Institute of Dental Research has estimated that we saved somewhere in the vicinity of \$40 billion in the 1980's as a result of the preventive—

Mr. SHERROD BROWN. That \$40 billion would likely be borne by the health care system the way that the two people in Florida—the way that the health care system bore those costs presumably, correct?

Mr. HILL. Right. Right. The estimates that are given by the Public Health Service are that treatment, the ratio of savings of prevention versus treatment is in the area of eight to one, so for every \$1 of prevention you save \$8 of treatment.

Mr. SHERROD BROWN. That is in the dental field.

Mr. HILL. Right.

Mr. SHERROD BROWN. Dr. Parkinson, overall do you have a similar kind of number?

Mr. PARKINSON. One of the advantages of having an historical legacy of never being paid for preventive services, we know exactly what they cost. It is interesting, I would refer, there is some excellent work that has been done by the National Coordinating Committee on Clinical Preventive Services and Estimates using Blue Cross Blue Shield data as well as provider data from the American Medical Association suggests that the annual cost per year to cover a package of screening, counseling, and immunization services along in this plan, similar to this plan, average about \$78 per year for females and about \$55 per year for males, the difference being of course Pap smears, mammography, more intensive physiological services among women.

When you get into the issue of how much money does that save you, I will be quite candid, it has been hard to prove in direct medical costs that an ounce of prevention does indeed save a pound of cure. What we do know is selective preventive interventions, most usually immunizations, for example, do save direct medical care costs, but I would argue, and the college of preventive medicine would argue, that that is a false rubric.

When Johnson & Johnson decides to set up a work site wellness center or cover well baby care, they do it for the indirect costs, the absenteeism, the cost to their company, the well-being of their employees. We have never had that freedom, if you will, but that is really the way to look at it.

For dollar for dollar, I can tell you that we have got cost-effectiveness studies for Pap smears and mammograms that talk about \$20,000 to \$50,000 per year life saved, those types of numbers, which are equivalent to diagnostic and therapeutic services.

Mr. SHERROD BROWN. I would like to make a comment, Mr. Chairman, in closing that that brings us around to the whole issue of the health alliances. When we talk about giving incentives for those companies that are smaller than 5,000 people joining health alliances, I mean, there is really—this plan, until we make some changes in it, may in fact provide some disincentives or at least take away the incentives to do the kind of wellness programs on work sites because they still get the indirect costs that you are talking about with less absenteeism and all that, but they don't get the insurance benefit, if you will, of long-term preventive care and what that means to those employees and those health care costs.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Brown.

Gentlemen, thank you very much for your testimony.

That concludes our hearing for today. We stand adjourned.

[Whereupon, at 2:43 p.m., the subcommittee was adjourned, to reconvene at the call of the Chair.]

[The following statements were submitted:]

TESTIMONY OF**ADAMISAT**

**(The Alliance to End Discrimination Against Mental Illness
and Substance Abuse Treatment)**

before the SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
of the COMMITTEE ON ENERGY & COMMERCE
U.S. HOUSE OF REPRESENTATIVES

**MENTAL HEALTH PROVISIONS IN THE
PRESIDENT'S HEALTH CARE REFORM LEGISLATION**

Chairman Waxmen and Members of the Subcommittee:

The Alliance to End Discrimination Against Mental Illness and Substance Abuse Treatment (ADAMISAT) objects to the discriminatory provisions of the President's Health Reform Plan which deal with victims of mental illness and substance abuse. ADAMISAT urges that the Plan be amended to provide non-discriminatory coverage.

Unlike treatment afforded all other diagnosed illnesses, the treatment of mental illness and substance disorder is singled out and arbitrarily cut short by the Clinton Plan. Patients treated in less expensive outpatient care settings which have the potential for the greatest efficacy and cost effectiveness are limited to 30 visits annually, often a medically inadequate standard of care. They are required also to bear a disproportionate co-insurance financial burden, far greater than patients with other illnesses or medical conditions. No other diagnosed illness is so stigmatized; no other treatment is so severely rationed without reason. There is no justification for such discriminatory treatment for victims of mental illness and substance disorder.

**THE ALLIANCE TO END DISCRIMINATION AGAINST
MENTAL ILLNESS AND SUBSTANCE ABUSE TREATMENT**

ADAMISAT was formed to ensure that national health care reform treats mental illnesses and substance disorders no differently than other illnesses and medical conditions.

ADAMISAT is comprised of a number of organizations and interest groups representing the spectrum of patients and providers. Its goals have been endorsed by the American Association of Private Practice Psychiatrists, the American Psychological Association, the National Federation of Societies for Clinical Social Work, the American Academy of Clinical Psychiatrists, the American Psychoanalytic Association, the American Ortho-Psychiatric Society, the American Society of Psychoanalytic Physicians and a dozen or more other organizations. The Alliance has collected and disseminated a wealth of data supporting nondiscrimination, developed factual and educational materials, and made presentations to the Gore Mental Health Task Force and Ms. Clinton's Health Reform Team. These efforts have been futile. Judging by what has been submitted to Congress as the President's Plan, the treatment of mentally ill individuals and those afflicted with drug disorders has been assigned the lowest rung on the national health care ladder. ADAMISAT holds that there is no rational basis to address mental illness and substance abuse in such a discriminatory and disparate manner.

THE CLINTON PLAN MUST BE AMENDED

ADAMISAT's goal is to ensure that the President's Plan is amended to prohibit discrimination in treatment and benefits for those diagnosed with a mental illness or substance disorder and to ensure patient access to qualified providers of care. Such an amendment would require that national health care legislation provide an individual afflicted with a mental illness or substance disorder with treatment equal in quality and as comprehensive as treatment for any other medical illness or condition.

To achieve this goal the language of the Clinton Plan must be amended in the following specific manner:

1. It must prohibit discrimination in the assessment of co-insurance, deductibles, premiums, or policy limits relating to mental health and substance abuse treatment services;
2. It must prohibit discrimination in the application of managed care methods, including those applicable to utilization review and preferred provider or

cooperative purchasing networks, and ensure patient access to the spectrum of qualified providers available; and

3. It must provide that any individual who suffers from a mental illness or substance disorder receive treatment comparable in quality, comprehensiveness, and availability as services received by an individual with any other illness or medical condition.

CLINTON PLAN DISCRIMINATORY PROVISIONS

While the legislation introduced on behalf of the Administration exhibits discrimination in approaching inpatient services and intensive non-residential services for the mentally ill, nowhere is such discrimination more evident than in the Plan's approach to outpatient services. For example, psychotherapy and collateral services are severely limited to annual limits of 30 visits. This arbitrary limit represents a serious restriction on a cost effective plan with proven efficacy which has no such restriction on treatment. Those Senators endorsing the November 17, 1993 letter to Mr. Magaziner at the White House stated it correctly: "Given the actuarial data concerning outpatient psychotherapy, moving to an increased benefit would make more fiscal and preventive sense than this reduction to a total of thirty visits."¹ Indeed, there is no empirical evidence which supports such a restrictive outpatient benefit. On the contrary, the scientific data (documents attached as Exhibit B) show the overwhelming advantages of an open or nondiscriminatory outpatient benefit and the financial unreasonableness of a thirty-visit outpatient visit limit with a fifty percent co-insurance burden on patients.²

¹See letter of November 17, 1993 to Mr. Magaziner from Senators Wellstone, Kennedy, Inouye, Domenici, Simon and Simpson attached as Exhibit A.

²Exhibit B consists of the following investigative reports: The CHAMPUS Program: Presentation of Alan B. Zients, M.D. (August 2, 1993); Synthesis of Research Relevant to Discussions for Including Mental Health and Substance Abuse Treatment as Part of Healthcare Reform at the National and/or State Levels (March 1993); Psychiatric Benefits in Employer-provided Healthcare Plans 1992 Report of Hay/Huggins Company, Inc. (August 4, 1992); and Cost Sharing and the Demand for Ambulatory Mental Health Services by Rand Corporation (September 1982).

NONDISCRIMINATION IS JUSTIFIED

Considering first the discriminatory outpatient component of the Clinton Plan, the weight of evidence regarding the efficacy and cost effectiveness of long term psychotherapy is compelling. At the same time, inadequate psychiatric care as proposed by the Clinton Plan leads to continuing disability and disfunction and often to increased medical, surgical and inpatient psychiatric costs. In this regard, we call your attention to Exhibit C to this submission: *The Long Term Psychotherapy Needs of Psychiatric Patients*; and *Mental Health Fact Book: A Basis for Assessing National Health Proposals*.

These monographs contain references and citations to much of the data, studies, investigations and the like which justify nondiscrimination when treating victims of mental illness and substance disorder. For example, the Mental Health Fact Book refers to the recent study of CHAMPUS. (This study is a part of Exhibit B.) CHAMPUS is a program covering approximately 4.5 million military dependant beneficiaries with a non-discriminatory mental benefit -- limited only by medical necessity including residential treatment and outpatient care. Military families are often at a higher risk for psychiatric illness given the disruption of social network and family stress which are a part of military life. In spite of the "at-risk" nature of the population, the cost of mental illness under CHAMPUS as the study points out has been a manageable \$106.00 per beneficiary. Notable also among the findings of the study is that utilization review for inpatient and residential treatment has reduced length of stay at acute psychiatric facilities from 18 to 13.3 days for adults and from 30 to 18.7 days for children. Residential treatment facilities have had reductions from 249.8 days to 158.4 days. Review of inpatient practices led to a decrease in expenditures and saved the government an estimated \$200 million dollars. Only minimal oversight of outpatient therapy has been necessary according to the study. And outpatient psychotherapy, while moderately increasing, has represented a far more cost effective delivery of services. In short, non-discrimination for mental illness and substance abuse treatment under the CHAMPUS program has saved money and returned significant dividends on the government's health care investment. Most recently, the need for such an investment was publicly documented in a study of depression which demonstrated the billions of dollars lost yearly to this dreaded disease.

The Alliance to End Discrimination Against Mental Illness and Substance Abuse Treatment is dismayed by the Administration's unwillingness to recognize the wealth of data that show the financial disadvantages of a severe limit on outpatient treatment and a 50% co-insurance burden on the patient. Studies justify the efficacy of the treatment, the very low cost of removing the limit and demonstrate the administrative nightmare that such limits and restrictive co-payments create in exchange for zero cost savings.³

The removal of these discriminatory and economically unsound limits on benefits for outpatient services must be a priority for all patient advocates including members of the Senate and House of Representatives. Indeed, encouragement of the most inexpensive treatment alternative -- outpatient care -- is imperative to the fiscal soundness of a benefit package which offers more expensive inpatient benefits to those who truly need them.

Of more fundamental concern regarding approaches to mental health in the President's Plan is the Plan's undue reliance on the concept of "managed competition" as being the preferred mechanism for the delivery of services within organized systems of care. To be sure, there are examples of mental health services delivered within organized systems which are fair and effective. Kaiser-Permanente had an open outpatient benefit prior to the enactment of federal HMO restrictions and the classical studies demonstrated its efficacy and cost-effectiveness. However, patients and clinicians alike can document the fact that in recent years many HMO's have provided services for mental illness which are far inferior to those provided for other illnesses as well as inferior to services provided in a traditional indemnity insurance setting.

Recently two studies supported this contention (Exhibit E). In the first, Rand Corporation investigators found that HMO patients suffering from depression not only did not improve compared to indemnity insured patients, they got worse! Even more recently, Dr. Kenneth Kessler, founder and former chief executive officer of American Psych Management, one of

³See letter from health care researchers Kenneth Wells and Willard Manning to Department of Health and Human Services with supporting data, squarely rebutting the Administration's cost projections (attached as Exhibit D).

the nation's leading mental health managed care firms, had the opportunity to review the experience of two additional managed care firms. He was able to document that HMO's had an 80% reduction in expenditures for mental health needs as compared to the expenditures in indemnity plans, whereas medical and surgical claims had been reduced only 20% to 25%.

CONCLUSION

It will not matter how many visits or days in the hospital are covered or what the co-payment will be if patients with mental illness and drug disorders are systematically denied access or are exposed to care of an inferior quality as compared to care offered to those with other illnesses or medical conditions. The President's Plan discriminates without cause or reason.

Therefore, ADAMISAT, in addition to the specific amendments noted above, recommends the consideration of the following provisions which would go far to ensure nondiscriminatory access and quality in a national health care scheme which relies heavily on rigorously organized delivery systems.

- i) Exempt by law those with mental illness or substance abuse complaints or symptoms from the need of "gatekeeper" approval for initial treatment; and
- ii) Require by law that all denials of certification for continued care be evaluated by a financially disinterested party, who is an active provider of similar services.

Finally, we wish to align ourselves with the Mental Health Liaison Group on aspects of this issue. Some ADAMISAT members are supporters of this group's objectives. We would support any and all improvements of the mental health provisions in the President's Plan which uphold nondiscrimination as a standard provision of medical services for every member of our society.

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December 8, 1993

(Subcommittee note: The exhibits referred to herein have been retained in the files of the subcommittee.)

AMERICAN ASSOCIATION for PARTIAL HOSPITALIZATION

DECEMBER 30, 1993

Chairman Waxman, Mr. Bliley, Members of the Committee:

First established as a Study Group in the mid-nineteen sixties, and later incorporated as a national association in 1972, the American Association for Partial Hospitalization (AAPH), is now the recognized voice of partial hospitalization and other intensive ambulatory forms of care with a national membership of over 1000 dedicated professionals and organizations committed to the ongoing development, growth, and improvement of partial hospitalization services within a continuum of ambulatory psychiatric and chemical dependency treatment. Our organizational membership consists of providers across the full spectrum of settings, including community mental health centers, free-standing facilities, general hospitals, and private psychiatric hospitals. Our individual membership also cuts across a full array of mental health professional groups, including psychiatrists, psychologists, clinical social workers, and psychiatric nurses. As a national association, we are committed to promoting the highest standards of care and to the development of a mental health system in which treatment needs are a primary consideration with cost or other considerations.

We are pleased to have the opportunity to provide testimony on the clinical efficacy and cost-effectiveness of partial hospitalization services, and to present our views on whether the

Health Security Act covers these services in a way that will ensure clinically appropriate treatment. Thank you for making our views part of the record of the hearing you held on December 8.

Intensive Non-residential Treatment Services Offers A Continuum of Ambulatory Care

Currently, most private insurance plans cover a narrow band of mental health services-- inpatient hospital care and outpatient visits to a mental health professional. This traditional approach to covering mental health services has ignored the range of ambulatory mental health services between inpatient and outpatient care. These services are critical to providing clinically appropriate care in the least restrictive environment. We applaud the Clinton Administration for mandating coverage of these services-- called "intensive non-residential treatment services" in the Health Security Act 1993. These services include partial hospitalization, day treatment, psychiatric rehabilitation, home-based care, and behavioral aides. While we have concerns on conditions stipulated in the Act which make these services difficult to access, *by simply mandating that these services are covered, the intensive non-residential treatment benefit in the Clinton plan offers a bold and progressive approach to treating people with acute and long term mental illnesses.* These services provide a continuum of ambulatory care, and if this Committee amends the mental health benefit in the way we recommend (see AAPH recommendations at conclusion of testimony), we believe that a patient will be able to move in and out of these services based on his or her clinical needs.

What is Partial Hospitalization?

Partial hospitalization has been referred to as a "hospital without the bed." It offers a time-limited, active treatment program which provides all of the components that one would get

through inpatient services but without an overnight stay. Examples of active treatment include: individual psychotherapy, group psychotherapy, medication evaluation, family therapy, and psychoeducational therapy groups such as symptom recognition and stress management. Partial hospitalization offers intensive, coordinated, and structured clinical services within a stable therapeutic environment. The primary goals include symptom relief, and reduction and prevention of psychiatric hospitalization. Partial hospitalization programs may either be free-standing or part of a community mental health center, general or psychiatric hospital, or residential setting. Ideally, a program provides six hours of scheduled treatment per day, five days a week.

With a history that exceeds 50 years, partial hospitalization became a widely accepted treatment modality when the Mental Retardation Facilities and Community Mental Health Center Act of 1963 mandated partial hospitalization services in community mental health programs. As one of the five required services, partial hospitalization was seen as a critical component for the deinstitutionalization of individuals with severe mental illnesses. Today partial hospitalization programs are viewed as part of the continuum of care for both acute and chronic mental illnesses.

The Principles of Partial Hospitalization Services

The AAPH has developed six principles which underlie the treatment approach of partial hospitalization services. These principles, listed as follows, are also generally applicable to the full continuum of ambulatory services made available through the intensive non-residential treatment services of the mental health benefit in the Clinton plan:

- Partial hospitalization services are designed for persons of all ages who present with a psychiatric and/or chemical dependency diagnosis and the need for treatment which is more intensive than outpatient office visits and less restrictive than 24-hour care.

- Partial hospitalization services provide a coordinated array of active treatment components which are guided by an individualized treatment plan and based upon a comprehensive evaluation of patient needs.
- Partial hospitalization services treat patients requiring intensive therapeutic intervention in a manner which simulates real-life experience and with the least amount of disruption to their normal daily functioning.
- Partial hospitalization services are available to patients on a consistent basis and are augmented with 24-hour crisis backup.
- Partial hospitalization services emphasize active involvement of the patient with both community and family resources.
- Finally, due to the matching of patient needs with targeted interventions, the provision of treatment in the least restrictive environment, and the reliance on patient strengths, resources, and family and community support systems, partial hospitalization services are cost efficient.

Targeted Population

Partial Hospitalization services possess an inherent capacity to effectively treat a broad range of conditions:

1. Individuals, who without the ongoing support of a partial hospitalization program, would in all likelihood require the protection and containment of an inpatient facility.
2. Individuals who are ready for discharge from an inpatient setting but in need of continued monitoring and assistance in transition back to the community.
3. Individuals who are unable to make significant gains within a traditional outpatient setting and need more intensive services.

These programs serve a range of patients, including children and adolescents, adults, and geriatric patients.

Benefits to Consumers

(1) For many patients who can maintain themselves in the community and who are not an imminent danger to themselves or others, partial hospital treatment eliminates the need to be treated in an inpatient setting, thereby removing the stigma of inpatient treatment.

It allows the patient to remain at home, fully integrated into the community. As such, patients are able to apply their new skills in their normal environment on a daily basis. Specially designed programs which take place in the evening or on weekends have the added benefit of allowing the individual to make gains while continuing to work. When appropriate, children and adolescents live with their families during treatment. By keeping an individual out of the hospital, studies have demonstrated that partial hospitalization can have an impact reaching far beyond a particular episode of illness and affect the entire course of treatment over a patient's lifetime.

Dr. Charles Kiesler of Vanderbilt University illustrated that patients who were admitted to the hospital even once, were more likely to be readmitted, whereas patients treated in community settings, such as the partial hospital program, were less likely to ever be admitted to the hospital.

(2) When used as a transition from an inpatient setting to the community, partial hospitalization can significantly lessen the inpatient length of stay and help to prevent rehospitalization, thereby resulting in significant savings.

(3) Partial hospitalization produces clinical outcomes superior to the outcomes of inpatient treatment.

In a review of 10 studies in which serious psychiatric patients were randomly assigned to either inpatient care or some alternative care, in almost every case, the alternative care had more positive outcomes. Further, none of the studies showed overall effects on outcome measures that were more positive for hospitalization than for alternative treatment.¹

¹. Charles A. Kiesler, American Psychologist, Vol 37, No. 4, April 1982, pp 349-360.

Cost Effectiveness

Cost-effectiveness has been demonstrated in comparison studies of partial hospitalization and inpatient treatment:

- Substituting partial hospitalization for inpatient care resulted in a 51% cost savings per inpatient episode.²
- Introduction of partial hospitalization for patients who were previously in inpatient, resulted in the mean length of stay per admission falling from 51 days to 17 days.³
- During a one year period, partial hospitalization reduced the number of days of hospitalization by 440%, from 1562 to 354 days.⁴
- During a one year period, partial hospitalization reduced the total number of hospital admissions by 220%, from 35 to 16.⁵

In a non-research setting, a leading insurance company saved a total of \$338,000 on 75 cases, an average of \$4,500 per case, due to the use of partial hospitalization and other alternatives to inpatient care using a process involving continued health review and use of individualized case management to identify options other than inpatient care.

Changes in admissions patterns in the last couple of years show that managed behavioral health plans have recognized the cost-effectiveness of partial hospitalization. According to Monica Oss, Editor of Open Minds, a newsletter which tracks trends in the behavioral health field, experience in California with several managed behavioral health plans indicates that inpatient utilization in larger employer groups has decreased by approximately 40% over the last two years. During this time, the use of partial hospital alternatives has increased from 15% of admissions to 36% of admissions.

². (Dickey et al., American Journal of Public Health, July 1989)

³. (Dickey et al., Hospital and Community Psychiatry, April 1990)

⁴. (Bateman, International Journal of Partial Hospitalization, Vol. 3, No. 1, 1985)

⁵. (Bateman, International Journal of Partial Hospitalization, Vol. 3, No. 1, 1985)

Federal Precedent Already Exists for Reimbursement of Partial Hospitalization Services

It is only in the last several years that public policy has recognized a body of research extending over 25 years which has consistently demonstrated the clinical efficacy and cost-effectiveness of partial hospitalization services. In the public sector, The Omnibus Budget Act (OBRA) of 1987 authorized Medicare coverage of partial hospitalization services provided in a hospital-based setting, and in OBRA 1989, Medicare coverage was extended to partial hospitalization services provided by community mental health centers. Further, on July 1, 1993, the Civilian Health and Military Personnel of the Uniformed Services (CHAMPUS) implemented a partial hospitalization benefit as a way to reduce the rising costs of inpatient care under the program while still providing clinically appropriate care.

By mandating that partial hospitalization services be provided by all accountable health plans, the Clinton Administration is building upon a precedent already established by the federal government which recognizes the value of these services.

AAPH Position on the Health Security Act of 1993

We believe that the Clinton Administration has created an historic opportunity to make health care coverage accessible and affordable for all Americans, and we are pleased that its proposal makes mental health services an integral part of the basic benefits package. Further, we are pleased that the Administration's plan eliminates annual and lifetime dollar limits on healthcare services, abolishes pre-existing condition exclusions, includes coverage for assessment, diagnosis and crisis interventions, and stresses prevention and early intervention.

The AAPH supports a reformed mental health system which ensures that all Americans have access to a broad array of services which are cost-effective and clinically appropriate. We list our concerns and recommendations, in priority order, as follows:

1. Under the Health Security Act, full comprehensive benefits without arbitrary limits would not occur until January 1, 2001, three years after the effective date for implementing the Act.

Recommendation: We recommend that the full comprehensive benefit without arbitrary limits be available upon the effective date of implementation, in 1998.

Justification: The three year period between enactment of the plan in 1994 and implementation in 1998 is sufficient time for providers to develop the management capacity and procedures to properly administer a comprehensive plan. Artificial limits on care are not only costly to the consumer but unnecessary as well. Already, many purchasers and providers are forming relationships by which the health plan furnishes a full continuum of services by a panel of multi-disciplinary providers and assumes financial risk and is accountable for the outcomes of care. As a result, the most appropriate and least costly level of care is selected based on individual need.

Many large businesses (like Honeywell, Chevron, Pacific Bell, and IBM) now know that managed care techniques are as effective-- and often more effective-- than the imposition of arbitrary and discriminatory limits on mental health care. For example, McDonnell Douglas Helicopter Company realized a decline in per capita costs of 34% under a managed mental health benefit, including a 50% reduction in psychiatric inpatient costs. First National Bank of Chicago removed its mental health coverage limits and also reduced inpatient costs by 50% over five years under a managed care approach.⁶ We believe that Congress should take notice of such experiences and build upon their successes by removing all discriminatory barriers to mental health services once and for all.

⁶. McDonnell Douglas Corporation. McDonnell Douglas Corporation Employee Assistance Program Financial Offset Study: 1985-1989, St. Louis, MO: McDonnell Douglas Corporation and Alexander Consulting Group, 1990; Washington Business Group on Health.

However, if it proves to be politically unfeasible to legislate a comprehensive mental health benefit without arbitrary limits in 1998, we have additional concerns and recommendations on the interim benefit structure:

2. In the intensive nonresidential component of the benefit, an initial 60 days are available only as a tradeoff with an already limited 30 day inpatient benefit. An additional sixty days are available, but an individual must pay a one day deductible and a 50% copayment under the high cost-sharing option.

While we are pleased that partial hospitalization is mandated to be provided in all accountable health plans as one of the intensive non-residential treatment services, we are concerned that the current benefit structure contains conditions which make the services difficult to access.

Recommendation: Restore the intensive non-residential treatment services benefit to the September 7 draft version of the Clinton plan which had a 120 day stand-alone benefit with no discriminatory high copayments.

Justification: Elimination of the tradeoff is necessary because consumers may decide not to access these less expensive, cost-effective services for fear that they may exhaust their inpatient benefit which they may need in a future crisis. Elimination of high copayments is necessary since the vast majority of people who need the additional sixty days--those with longer term and persistent mental illnesses-- generally can not afford the prohibitively high copayments.

3. The bill provides 30 days of outpatient psychotherapy and, as an alternative to hospitalization, additional days are made available on a 4:1 substitution ratio with inpatient days.

Recommendation: Eliminate the tradeoff and expand the outpatient psychotherapy benefit to 50 days per year.

Justification: Since there is no compelling body of research evidence which shows that outpatient psychotherapy can be used as an effective alternative to psychiatric hospitalization,

there is no clinical basis for the condition of the trade-off as stated in the Clinton plan. While we would prefer a benefit with no arbitrary limits (as elaborated in recommendation #1), at least a 50-day limit would preserve the once-a-week session which is typical of this treatment approach.

Finally, in addition to our concerns about benefit structure, we have a broader concern about *inadequate quality standards for delivery of services*. Individuals with chronic illness, both mental and physical, are at risk of being denied essential services in managed care settings. The experience with HMOs in limited care to people with serious mental illness demonstrates that providers operating under capitated premiums have strong incentives to undertreat high cost patients.

Health care reform legislation should not create a culture in which clinically necessary services are inappropriately denied or approved too late. Instead, the legislation should emphasize early intervention, quality assurance standards and effective monitoring to assure that consumers receive services in the amounts and settings appropriate to their conditions. We offer our assistance to assure that appropriate legislative language is crafted to address this concern.

AAPH looks forward to working closely with the Committee in helping to shape a mental health benefit which ensures access to a full continuum of clinically appropriate mental health services.

Statement of the American Association of Oral and Maxillofacial Surgeons

I. INTRODUCTION

The American Association of Oral and Maxillofacial Surgeons (AAOMS) appreciates the opportunity to submit this statement for the record and convey our views on the Health Security Act of 1993.

The AAOMS, founded in 1918, represents more than 6,000 oral and maxillofacial surgeons, and is one of the oldest surgical specialty organizations in the United States. Oral and maxillofacial surgery (OMS) is the surgical specialty of dentistry that deals with the diagnosis, and surgical and adjunctive treatment of diseases, injuries, deformities, defects and esthetic aspects of the oral and maxillofacial regions.

An oral and maxillofacial surgeon is a dental school graduate who has completed a postgraduate hospital residency in an accredited oral and maxillofacial surgery training program, including a core surgical year. This year of comprised of rotations in internal medicine, general surgery and anesthesia services. In addition, she or he completes a minimum of 30 months of surgical training focused in the maxillofacial region. Oral and Maxillofacial surgeons treat a significant number of patients in an outpatient setting. Their expertise in this area includes in-depth knowledge of ambulatory general anesthesia and sedation, gained through residency training and an in-office evaluation program required by the specialty. The AAOMS is dedicated to continuing education, clinical research, and quality of patient care in the field of oral and maxillofacial surgery.

The AAOMS has been progressive in its endeavors to advance the specialty of oral and maxillofacial surgery. Through the establishment of the Oral and Maxillofacial Surgery Foundation, the specialty has committed itself to continuing improvement of patient care through support of education and research. The OMS has raised more than \$5.1 million for the Foundation's Endowed Research Fund to ensure the long-term availability of funding for research in oral and maxillofacial surgery. In the past two years alone, the OMS has awarded \$380,000 to research applicants.

Furthermore, the AAOMS has been in the forefront of the health care field as one of the first specialties to develop parameters of care. The establishment of these parameters provides a means to assess the appropriateness and quality of treatment to patients treated by oral and maxillofacial surgeons. This represents the strong commitment to patient care and accountability of the specialty of oral and maxillofacial surgery.

The AAOMS was one of the eighteen specialties examined in Phase I of the Harvard Resource-Based Relative Value Study. Since then the AAOMS has worked closely with Harvard, the Physician Payment Review Commission and the Health Care Financing Administration to refine the Medicare payment system.

II. AAOMS POSITION AND VIEWS ON HEALTH CARE REFORM

In viewing the development of health care policy, the AAOMS has identified some issues with respect to health care reform legislation of critical concern to oral and maxillofacial surgeons.

The most important issue for any health care provider is to assure that patients have access to care, and that providers have the ability to provide it as well and as efficiently as possible. With that in mind, our central concern is that any health care reform plan not permit

discrimination against oral and maxillofacial surgeons because of their academic degrees in dentistry. ●

Degree of provider discrimination occurs when a licensed and highly trained oral surgeon is subjected to diminution of authority, refusal of reimbursement, or restriction in providing services solely on the basis on his or her academic degree. These practices by third parties are detrimental to the effective delivery of health care. This can result in preventing the public from receiving care from the health care provider most experienced and skilled in handling the needed procedures. This ultimately translates to increased costs to the consumer and a lower quality of health care.

Degree Recognition

Oral and maxillofacial surgeons have a long history of providing care for trauma (See Attachment 1). Yet, over the years, other oral and maxillofacial surgeons have encountered health plans that limit our participation or reimbursement because we have a dental degree and not a medical degree. For instance, there are plans which cover treatment for a fractured jaw, but only when the services are provided by an M.D., even though it is a procedure for which we are trained and licensed.

Oral and maxillofacial surgeons have also been discriminated against by plans that permit a non-M.D., such as an oral and maxillofacial surgeon, to provide treatment, but then reimburses the provider at a differing rate because of their academic degree. This arbitrary distinction has nothing to do with the provider's ability or experience and therefore should not be permitted. We believe that no health care reform legislation should permit managed care plans to discriminate against health care providers, in the areas of participation or reimbursement, because they hold or do not hold one type of academic degree. This problem is widely recognized at the state level, where 46 states have enacted legislation prohibiting discrimination based on the academic degree of the provider.

This concept of equality between oral and maxillofacial surgeons and M.D.s, and prohibiting degree of provider discrimination is endorsed not only by the AAOMS, but by the Medicaid and Medicare systems with their adoption of a physician definition that includes oral and maxillofacial surgeons, and by 46 states. In implementing the Resource Based Relative Value Scale in the Medicare payment system, the 1989 Omnibus Budget Reconciliation Act dictated equal payment for the same service regardless of provider academic degree. That mandate has been specifically and repeatedly endorsed by Congress, the Physician Payment Review Commission, the Health Care Financing Administration and Harvard during the past five years (See Attachment 2).

Degree of Provider Protection and The Health Security Act

As proposed, the Health Security Act recognizes the importance of prohibiting degree of provider discrimination. Its definition of health care providers and health professional services encompasses individuals legally authorized by states to deliver health care services. By not distinguishing between M.D.'s and other health care providers, the Act would prohibit some forms of discrimination. In addition, the Act prohibits health alliances and health care plans from discrimination against the mix or anticipated need for health professionals.

However, by not explicitly prohibiting degree of provider discrimination, the Administration's proposal does not adequately address our concerns.

We believe the Health Security Act of 1993 should prohibit state, regional or corporate health alliances or other plans from discriminating in employment, contracting, participation, reimbursement, or indemnification against a doctor of dental surgery or of dental medicine who is acting within the scope of the dentist's professional license under applicable State law, solely based on the academic degree of the provider.

This language does not require a plan to reimburse oral surgeons or any type or category of provider. Moreover, the language would not prohibit a plan from limiting the number and type of health care providers, and would not require that any additional or related services be covered. Rather, the language merely prohibits a plan that already provides coverage for certain services (e.g. surgery for a jaw fracture as a result of an automobile accident) from discriminating against an oral or maxillofacial surgeon solely because he or she is a dentist who is licensed to perform such services and not a medical doctor.

Hospitalization of Patients

As oral and maxillofacial surgeons, we, like other doctors, have patients who vary in their physical condition, medical history and pain tolerance. To provide our patients with the highest quality of care, the least amount of risk or discomfort, we must have the authority to hospitalize patients when their medical condition so dictates. This authority currently exists in virtually all U.S. hospitals accredited by the Joint Commission on the Accreditation of Health care Organizations (JCAHO).

We believe that the needs of the patient and the experience, training, and ability of the health care provider should be the critical factors that determine plan participation and reimbursement policies. Our specialty is unique in its training curriculum and its scope. We bridge the disciplines of dentistry and medicine. Our scope of practice encompasses dental and medical procedures, and although the distinction between which procedures fall under what heading is at times clear cut, at times there exists a significant overlap. Oral and maxillofacial surgeons complete dental school, at least an additional four years of residency, and have clinical experience in medicine, surgery and anesthesia. (See Attachment 3).

As surgeons, nearly all of us work in a hospital setting, and are subject to each hospital credential committee's high and stringent standards that are based on the JCAHO. Education, training, experience and quality assurance ensure that patients receive the best care from the best qualified individuals.

III. COVERAGE OF ORAL AND MAXILLOFACIAL SURGERY SERVICES

Obviously, the issue of cost will likely determine what is included in the final version of any health care reform legislation. At this time, the AAOMS does not have sufficient information on the parameters of the Health Security Acts benefit plan to provide the Subcommittee with specific recommendations on which oral and maxillofacial surgery procedures should be covered. However, we have reviewed the provisions of the Administration's proposal and believe the following critical procedures performed by oral and maxillofacial surgeons should be considered as included in the plan's comprehensive benefit package:

1. Anesthesia

The specialty of OMS pioneered the delivery of outpatient anesthesia, over forty years ago. Through a continuous process of refinement of existing techniques and the adoption of new procedures, fully 75 percent of OMS care is now delivered in the outpatient setting. Sedation and general anesthesia form the cornerstone of our ability to provide this public service. We believe that this medical service should be included in any basic health care package.

2. Birth Defects, Growth, and Development Problems

We subscribe to the notion that there is little as important as providing optimum care to the young among us. We therefore believe that any congenital defects must be addressed as expertly and expeditiously as possible so that all can become fully participatory in our society.

An example of some of these defects are cleft lip and/or palate, facial clefts, hyperplasia, hypoplasia, aplasia, neoplasia, hypertelorism, dystopia, Crouzon's syndrome, Apert's syndrome, Treacher-Collins syndrome, or identified by other descriptive terminology.

Similarly, we adhere to the belief that those among us who suffer growth and development problems resulting in not just stunted physical development be granted the same opportunity of care.

Our ability to correct the function of the facial skeleton as well as the correction of hard and soft tissue deficiencies secondary to congenital and acquired defects should be an integral part of any basic health plan.

3. Trauma

Trauma remains a major health and social issue in the United States. Every year, hundreds of thousands of people of all ages sustain facial injuries from automobile and bicycle accidents, athletic activities, or altercations. Many of these injuries are maxillofacial fractures - fractures of the lower jaw, upper jaw, palate, cheek bones, nasal bones, bones surrounding the eyes, or combinations of these types of facial fractures.

Our involvement in facial trauma is all inclusive. Such facial trauma all too often causes significant oral disruption resulting at times in serious interference with one's ability to masticate, swallow, breath, smell and see. Treatment of these patients often requires hospitalization and the skills of professionals trained in trauma management. The patient may have chronic pain, and those with extensive residual defects frequently become emotionally impaired. Due to tissue loss, subsequent reconstructive procedures are often necessary to allow the patient to re-enter society expeditiously and fully functional.

The principles of treatment of a facial fracture are the same as for a fractured arm or leg. The parts of the bone must be aligned (reduced) and held in position (fixed, stabilized) long enough for healing to occur. This may require six weeks or more, depending upon the patient's age and the complexity of the fractures. When fractures are extensive, multiple incisions to expose bones in order to employ a combination of reduction and fixation techniques (e.g., wiring or plating) may be needed.

4. **Pathology**

Pathology of the maxillofacial region includes tumors, both malignant and benign, and infections of odontogenic (dental) and non-odontogenic origin. Pathology also includes disorders of the temporomandibular joint, which often result in severe pain and dysfunction. The disabilities resulting from a dysfunction of this joint are no different than those emanating from joints anywhere else in the body. Again, the reconstruction of any anatomical disruption resulting in dysfunction is an indivisible part of therapy.

Finally, we endorse the view that reconstruction of deformities or disease conditions resulting from prior surgery should be treated the same as other surgical or therapeutic procedures.

IV. **CONCLUSION**

Oral and maxillofacial surgeons also perform other outpatient dental procedures, which are normally covered under dental insurance policies, and are not included in our recommendations for health care reform.

The AAOMS is currently evaluating the development of a more specific list of prioritized OMS services. Such a list could be relevant to the determination of which OMS procedures should be included in a standard benefit package. As Congress proceeds in its deliberations of any health care reform legislation, including the Health Security Act of 1993, the AAOMS will be available to discuss the specific details of the health care plan with the members of the Energy and Commerce Subcommittee on Health and the Environment.

If you desire any further information, please contact the Association:

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WRITTEN SUBMISSION OF STANLEY B. PECK, EXECUTIVE DIRECTOR
on behalf of
THE AMERICAN DENTAL HYGIENISTS' ASSOCIATION

BEFORE THE HOUSE COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
HEARING ON HEALTH BENEFITS PROPOSED
UNDER THE CLINTON HEALTH SECURITY ACT
December 8, 1993

The American Dental Hygienists' Association (ADHA) is the largest national organization representing the professional interests of the approximately 100,000 dental hygienists across the country. Dental hygienists are preventive oral health professionals, licensed in dental hygiene, who provide educational, clinical and therapeutic services that support total health through the promotion of optimal oral health.

ADHA is pleased that reform of the nation's health care delivery system is one of Congress' highest domestic priorities. We are committed to participating in this process to ensure universal access to cost-effective quality health care, including, at a minimum, preventive oral health services. Oral health is a part of total health and the oral health care delivery system requires reform along with the medical care delivery system.

ADHA is pleased that the Health Security Act proposed by President Clinton includes preventive and primary dental care for children as well as emergency care for both children and adults. However, in light of the proven cost-effectiveness of preventive oral health care -- where each \$1 spent yields \$8-\$50 in savings -- ADHA feels strongly that preventive and other basic oral health care benefits should be provided to adults from the outset. As currently written, the Clinton plan would phase in additional dental benefits for adults by the year 2001.

ADHA has joined the Coalition for Oral Health, which includes approximately twenty-five national oral health organizations, to press for the inclusion of cost-effective oral health benefits in health care reform legislation. The Coalition, using U.S. Public Health Service data, has developed a preventive and primary oral health package for children and adults which would cost a modest **less than \$10 per person per month**. *This package would include: preventive services consisting of a professional oral health assessment, dental sealants, professionally-applied topical fluoride, an annual dental cleaning (oral prophylaxis), and fluoride supplements; acute, emergency dental services; early intervention services (to maintain and restore function) including restorative services and periodontal maintenance services; and certain accommodations for persons with disabilities.*

Access to Oral Health Care

The Institute of Medicine estimates that fifty percent of Americans do not receive regular dental care. Further, while 37 million Americans lack medical insurance, the National Dental Research Advisory Council reports that 150 million Americans lack dental insurance, and millions more are underinsured for health care, including oral health care.

Preventable oral diseases currently afflict the majority of children and adults in our country. Dental caries (tooth decay), gingivitis and periodontitis (gum and bone disorders) are the most common oral diseases. In fact, the Public Health Service reports that fifty percent of all children in the United States experience dental caries in their permanent teeth and two-thirds experience gingivitis. Furthermore, nearly half of all employed adults have gingivitis and eighty percent have experienced periodontitis, according to the U.S. Preventive Services Task Force. If untreated, gum disease causes bone deterioration and eventual loss of teeth, pain, bleeding, loss of function, diminished appearance, and possible systemic infections. Indeed, as many as four to fifteen percent of American adults, and more than forty percent of the elderly, have lost all their teeth. These individuals frequently experience nutritional deficiencies as a result of being unable to chew food. Each of these oral health disorders -- dental caries, gingivitis and periodontitis -- can be prevented through regular preventive care.

Universal access to oral health services should be provided to all Americans as one way to support total health. Ideally, everyone should have access to diagnostic, preventive, restorative and periodontal care, as well as emergency care to treat pain. At a minimum, however, preventive services should be available as an investment for long-term savings.

Children, in particular, should be assured regular preventive services. The American Academy of Pediatrics supports a fully funded preventive care benefit package -- which includes preventive dental care -- as a component of its recommended basic benefit package for children. The Medicaid Early and Periodic Screening Diagnosis and Treatment (EPSDT) program also recognizes the value of preventive oral health care for children, mandating coverage of these services for all Medicaid-eligible individuals from birth to age 21. Because of financial and other restrictions imposed by states, however, the September 1989 "Public Health Service Workshop on Oral Health of Mothers and Children" revealed that the Medicaid program continues to serve only a fraction of the children it was intended to serve.

Preventive oral health care has already proven beneficial. The National Institute of Dental Research (NIDR) reports that one-half of American children ages five to seventeen are now cavity free. Although the prevalence of dental caries among school-aged children has declined in recent years, 84 percent of 17-year olds were found in a recent NIDR survey to have cavities. Further, the Centers for Disease Control reports that the oral health of African Americans and Hispanics is far worse than that of whites. For example, one of the most severe forms of gum disease -- localized juvenile

periodontitis -- disproportionately affects teenage black males and can result in loss of all teeth before adulthood.

Americans with access to preventive dental services highly value this care, as illustrated by federal government workers. The Washington Post recently reported that 1.5 million of the four million current and retired federal workers who participate in the Federal Employees Health Benefits (FEHB) program choose the Blue Cross-Blue Shield policy, in part because of its preventive dental package, which includes dental exams, X-rays, prophylaxis (cleaning) and fluoride treatments. In addition, Hewitt Associates (Hewitt), an international consulting firm specializing in employee benefit plans, reports that 92 percent of the health plans in its data base include dental coverage.^{1/} Hewitt also reports that employees ranked dental coverage second in importance only to medical coverage and before all other benefits, including paid time off, pension options, sick leave and life insurance.

Cost Savings Associated With Preventive Oral Health Care

Investing in America's oral health care will translate directly into fiscal savings. It is a known fact that preventive care can reduce the need for expensive critical care. In fact, NIDR reported in July 1992 that Americans saved nearly \$100 billion in dental bills during the 1980s because of improvements in oral health. Each \$1 spent on preventive oral health care yields \$8-\$50 in savings.

Remarkably, while economic factors, such as population growth, increases in numbers of dentists, and increases in numbers of Americans with dental insurance, might have significantly increased the growth in dental expenditures over the past decade, National Income and Product Accounts data from the U.S. Commerce Department indicate that average annual growth in total real dental expenditures, adjusted for inflation, was only one percent annually from 1979 to 1989. This was substantially less than growth in medical expenditures. This slower growth in dental expenditures is estimated to have resulted in savings to the American public of more than \$39 billion in 1990 dollars from 1979 through 1989. Increased emphasis on prevention, widespread use of fluorides, and a better-informed public contributed to those cost savings.

Even with these savings, however, there is room for significant improvement. In fact, the American Fund for Dental Health reports that 20 million work days are lost annually due to oral health problems. Increased access to preventive oral health services

^{1/} Hewitt Associates March 30, 1993 testimony before the House Ways and Means Subcommittee on Health, "HealthCare Reform: Consideration of Benefits for Inclusion in a Standard Benefits Package," stated that it maintains a data base covering the salaried employees of over 1,000 major employers and the hourly and union employees of more than 200 major companies. These employers provide benefits to more than 20 million employees and 35 million of their spouses and dependents.

undoubtedly would reduce this staggering number and exponentially increase cost savings.

A working draft report prepared by the Public Health Service's Oral Health Coordinating Committee entitled "An Essential Oral Health Benefits Package" estimates an annual per capita cost of \$74 to provide all American children with comprehensive oral health services^{2/} and all American adults with only acute emergency and preventive services.^{3/} Thus, the estimated cost of providing these services would be \$19.2 billion for the entire population or \$11.8 for the 160 million Americans who presently lack dental insurance. The report further estimates that extending comprehensive coverage to all Americans would entail a per capita cost of \$134 or \$34.9 billion for the entire population or \$21.5 billion for the dentally-uninsured. [See attached table.]

The Coalition for Oral Health, which includes ADHA and other national oral health organizations, is advocating the inclusion of a cost-effective oral health benefits package in health care reform legislation. The Coalition, using U.S. Public Health Service data, has developed a preventive and primary oral health package for children and adults which would cost a modest **less than \$10 per person per month**. *This package would include: preventive services consisting of a professional oral health assessment, dental sealants, professionally-applied topical fluoride, an annual dental cleaning (oral prophylaxis), and fluoride supplements; acute, emergency dental services; early intervention services (to maintain and restore function) including restorative services and periodontal maintenance services; and certain accommodations for persons with disabilities.*

Role of Dental Hygienists in Providing America's Oral Health Care

As the primary providers of preventive oral health services, dental hygienists stand ready to aid the nation in improving its delivery of oral health care and subsequently contributing to total health by providing valuable services such as routine prophylaxis; periodontal assessment, treatment and maintenance; application of fluorides and sealants; x-rays; and education in self care. By helping patients modify personal health

^{2/} Services recommended include professional oral health assessment, consisting of thorough examination of the hard and soft tissues of the oral cavity and related structures provided on an annual basis, for those age two and older; dental sealants for permanent molar teeth in children; professionally-applied topical fluoride provided up to twice a year for children and adults who are assessed to be at risk for dental caries; oral prophylaxis (cleaning) for the removal of hard and soft deposits and extrinsic stain; and fluoride supplements made available to children until age 13 whose water supply contains sub-optimal levels of fluoride, acute emergency dental services, dental restorative services, and periodontal maintenance services.

^{3/} Adult preventive services would include oral health assessment, oral prophylaxis, periodontal maintenance services, professionally-applied topical fluoride for adults at risk for dental caries, and acute emergency dental services.

behaviors to promote self care, dental hygienists assist individuals in playing a vital and cost-effective role in their own oral health.

As Congress reforms the health care delivery system, lawmakers thus should not view dentists as the gatekeepers of oral health services, akin to the primary care physician whose status may be elevated to that of gatekeeper of the provision of medical services in the future. The role of a dentist in the delivery of oral health care is not akin to that of a primary care physician. The preventive oral health services which ADHA is advocating be included in a standard benefits package should be available to all Americans when provided by any state licensed provider. Both dental hygienists and dentists are licensed in all 50 states and therefore have demonstrated their competence to the satisfaction of state licensure boards whose mission it is to ensure the health, safety and welfare of the public. Further, dental hygienists receive three times the amount of education in preventive oral health services as do dentists.

Federal legislation should ensure direct access to dental hygienists by providing for direct reimbursement in order to maximize Americans' access to preventive oral health care services. We must break down arbitrary practice setting barriers to access which have long tied oral health care delivery to the fee-for-service private dental office, where only 50 percent of the population is served. Several states, including Colorado and Washington, have endorsed direct access to dental hygienists through legislation which permits dental hygienists to practice independently. These states expressly have recognized that full utilization of the services of dental hygienists can address the need to augment the delivery of oral health care. Federal law in no way should impede the progress that states are making in recognizing that dental hygienists appropriately may provide preventive oral health services outside of the purview of a dental office, thus breaking down the barriers which have impeded access to oral health services for too long.

A 1987 Federal Trade Commission study entitled Restrictions on Dental Auxiliaries, An Economic Policy Analysis recommends the elimination of licensing laws which limit the number of dental hygienists in a dentist's practice, finding that increased use of dental hygiene services will decrease costs to the consumer and improve access, without compromising quality. It is critical for federal legislation to buttress, and not impede, state law efforts to ensure increased access to dental hygiene services for children, the elderly, minorities, the poor, and the traditionally underserved. Indeed, recently proposed Medicaid EPSDT program rules for dental screening services would provide for referral to a dentist *or a professional dental hygienist* under the supervision of a dentist as an option to satisfy the requirement for initial referral for dental services. The stated rationale is to "increase the availability of dental services in areas where dentists are scarce or not easy to reach." Any federal legislation that provides for preventive oral health care services must protect patients' direct access to dental hygienists by providing for direct reimbursement.

Conclusion

In conclusion, preventable oral diseases still afflict the majority of children and adults in our nation, compromising their health and unnecessarily adding to health care costs. Ideally, all Americans should have access to diagnostic, preventive, restorative and periodontal care, as well as emergency care to treat pain. But, at a very minimum, Americans need access to basic preventive oral health care, including education in self care, routine teeth cleaning, provision of fluorides and sealants, periodontal maintenance and routine x-rays. Any federal legislation that provides for preventive oral health benefits also must ensure Americans' access to dental hygienists, the primary providers of preventive oral health care services.

ADHA stands ready to work with the nation's policymakers to ensure every American basic oral health and the savings of billions of health care dollars.

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TABLE IV. Oral Health Benefits Package
Primary Preventive, Acute Emergency & Early Intervention Services
Targeted for Children, Adolescents, Adults, and Seniors

Basic Oral Health Service <i>Primary Prevention & Acute Emergency Services</i>	Target Population	Provider-Based Services (Guidelines / Modifiers / Estimated Costs)				
		Frequency of Service (N/Year)	Utilization Rate _a	Specific Service Modifier	Estimated Unit Cost (\$/unit) _b	Estimated Annual Per Capita Cost
Oral Health Assessment	Children / Adolescents & Adults / Seniors					
• Initial Oral examination		1	70 %	—	\$22	\$15
• Periodic Oral Examination		1	70 %	—	\$17	\$12
• Dental X-rays (2 bitewings)		1	70 %	—	\$16	\$11
Dental Sealants	Children & Adolescents ^c (8 and 14 years)	1	50 % ^d	4 molars ^e	\$19	\$38
Professionally-Applied Topical Fluorides	Children & Adolescents (Non-Fluoridated Areas)	2	85 % ^f	45 % ^g	\$16	\$12
	Children & Adolescents (High Risk – Fluoridated Areas)	2	20 % ^h	55 % ⁱ	\$16	\$ 4
	Adults (High Risk of Caries)	2	70 %	10 % ^j	\$16	\$ 2
	Seniors (High Risk of Caries)	2	70 %	10 % ^j	\$16	\$ 2
Oral Prophylaxis (Dental Cleaning)	Children & Adolescents	1	70 %	60 % ^k	\$28	\$12
	Adults & Seniors	1	70 %	40 % ^l	\$39	\$ 11
Fluoride Supplements (Daily Supplements)	Children (13 years and under) ^m	1 (daily)	85 % ^f	45 % ^g	\$16	\$ 6
Acute Emergency Dental Services	Children / Adolescents & Adults & Seniors					
• Emergency Examination		1	15 % ⁿ	—	\$23	\$3
• Sedative Filling		1	2 %	—	\$31	\$1
• Emergency Tx of Pain		1	2 %	—	\$34	\$1
• Extraction (single tooth)		1	10 %	—	\$47	\$5
• Extraction (surgical)		1	1 %	—	\$86	\$1
• Traumatic wound Tx		1	1 %	—	\$55	\$1

Basic Oral Health Services Early Intervention Services	Target Population	Provider-Based Services (Caldwell's / Modifiers / Estimated Costs)				
		Frequency of Service (N/Year)	Utilization Rate _a	Specific Service Modifier	Estimated Unit Cost (\$/unit) _b	Estimated Annual Per Capita Cost
Dental Restorative Services (Dental fillings)	Children (Primary Teeth) (3 to 10 years) ^c	1	70 %	1.1 surfaces ^d	\$38	\$30
	Children & Adolescents (Permanent Teeth) (6 to 18 years) ^e	1	70 %	0.4 surface ^f	\$44	\$12
	Adults (Coronal Caries)	1	70 %	1.3 surfaces ^g	\$44	\$40
	Adults (Root Caries)	1	70 %	0.4 surface ^h	\$44	\$12
	Seniors (Coronal Caries)	1	70 %	1.54 surfaces ^h	\$44	\$46
	Seniors (Root Caries)	1	70 %	1.46 surfaces ⁱ	\$44	\$46
Periodontal Maintenance Services (Dental scaling and root planing)	Children & Adolescents	1	70 %	10 % ^j	\$60	\$4
	Adults	1	70 %	54 % ^k	\$60	\$23
	Seniors	1	70 %	66 % ^l	\$60	\$28

FOOTNOTES: Assumptions used in the development of the Oral Health Benefits Package

- a Estimated utilization rate—The proposed oral health service package projects an overall utilization rate of 70 percent for the target population, unless disease conditions or other modifying factors warrant adjustment of this rate.³⁰ National dental care utilization data (NHIS, 1989) reports an overall annual utilization rate of 57 percent.³ *Healthy People 2000* has set a goal of 70 percent utilization of the oral health care system for adults aged 35 years and older.³³ Recommend that future cost estimates be based on a utilization rate of 70 percent for all age categories.
- b Unit cost of dental services—Cost estimates for individual clinical-based services are based on 1985 median fees from a national survey of dentists conducted by the American Dental Association³ and adjusted to 1992 dollars.
- c Eligible population—The services package targets the population of two age groups (8 and 14 year old children) for placement of dental sealants on susceptible permanent molar teeth, in any one year.³⁰ Recommend the application of sealants to a total of eight (8) permanent molar teeth per individual during the period of 7 to 15 years of age.³⁴
- d Utilization modifier—A modified utilization rate of 50 percent for sealant application is recommended based upon the target goal of 50 percent established in *Healthy People 2000*.³³ In 1989, only 17 percent of eight year old children, and 13 percent of children aged 14 years, were reported to have sealants.²
- e Service modifier—The preventive services package recommends a single application of dental sealants to four (4) permanent molar teeth per individual, in any one year, during the period of 7 to 15 years of age.
- f Utilization modifier—The benefit package employs an 85 percent utilization rate, which corresponds to the *Healthy People 2000* target goal for individuals not receiving optimally fluoridated public water.³³

- g Service modifier**—The Centers for Disease Control and Prevention (CDC) estimates that approximately 112 million people (or approximately 45 percent) in the U.S. (1989) did not have access to the benefits of optimally fluoridated water, either through adjusted or naturally occurring means.⁴ Assuming the U.S. population served by community and non-community water supplies is distributed evenly by age category, this service package assumes that 45 percent of the child population consumes drinking water with less than optimal levels of fluoride. Thus, this figure represents the proportion of the U.S. population not receiving water with a dentally significant concentration of fluoride and would benefit most from the application of professionally-applied topical and systemic fluoride supplements. Children and adolescents consuming dentally significant concentrations of fluoride in their drinking water should not be prescribed dietary fluoride supplements.
- h Utilization modifier**—A modified utilization rate of 20 percent is used in the model to represent the proportion of the U.S. child population at high risk of experiencing dental caries, and thus would benefit from additional topical fluoride treatment—even those residing in fluoridated areas. This estimate is based on the 1986-87 National survey of oral health in school children that reported 60 percent of the decayed teeth in children were found in 20 percent of the individuals surveyed.¹⁹
- i Service modifier**—The CDC estimates that over 128 million people (1989) in the U.S. in more than 8,081 communities are receiving the benefits of optimally adjusted fluoridated water, and an additional 9 million people in 1,869 communities are using water with naturally occurring fluoride at levels of 0.7 mg/liter or higher.⁴ Assuming the child population served by community and non-community water supplies is distributed evenly by age category, the service package used the estimate of 55 percent as the proportion of the U.S. child population with access to drinking water with a dentally significant concentration of fluoride. This population would not benefit significantly from professionally-applied topical fluoride, unless there is evidence the individual is at increased risk of dental caries (see footnote h).
- j Service modifier**—The National Institute of Dental Research (NIDR) conducted the 1985-86 National Survey of Oral Health in U.S. Employed Adults and Seniors and reported that approximately 7 percent of employed adults (dentate) aged 18-64+ years were caries free, and about 3 percent of dentate seniors aged 65+ (dentate) were caries free.¹⁰ Although only a small proportion of adults/seniors were found to be caries free, an estimate of 10 percent was project as the proportion of adults/seniors at increased risk of active dental caries and would benefit from fluoride supplements. The service modifier is based upon the survey findings that the decayed component (D) of caries scores (unrestored tooth surfaces) comprised approximately 8 percent in employed adults and 9 percent in seniors of the decayed and filled tooth scores (DFT).¹⁰
- k Service modifier**—The proportion of children and adolescents requiring "routine oral prophylaxis" is estimated to be 60 percent. This estimate is based on the 1986-87 NIDR National Survey of Oral Health in School Children which reported 59 percent of children aged 14-17 years demonstrated gingival bleeding upon probing.¹¹ Gingival bleeding serves as an indicator for mild or moderate gingival inflammation and an indirect measure of treatment need required.
- l Service modifier**—Approximately 89 percent of the adult population aged 18 and older is classified as dentate.¹⁰ The proportion of dentate adults aged 19 to 64 years and dentate seniors aged 65+ years requiring "routine oral prophylaxis" is estimated at 40 percent. Projection based of data from the 1985-86 NIDR National Survey of Oral Health in U.S. Employed Adults and Seniors — 43.6 percent of employed adults (dentate) aged 18-64+ years were reported with gingiva bleeding in at least one site; and 46.9 percent of seniors (dentate) were reported with bleeding gingiva.
- m Eligible population**—The target population includes infants and children, 13 years of age and younger. Daily use of dietary fluoride supplements is recommended for infants (pediatric drops) and children (fluoride tablets) up through the age of 13, who reside in areas not served by fluoridated public or private water supplies.¹⁴
- n Estimated utilization rate**—The estimated need for emergency dental services is 15 percent. Based on data from the 1985-86 National Survey of Oral Health in U.S. Employed Adults and Seniors — 18.6 percent of employed adults, and 16.2 percent of seniors self-reported the need for "immediate" dental treatment.¹⁰ From the same national survey, 14 percent of adults and seniors reportedly sought dental care for either a toothache or to have a tooth extracted.¹⁰

- o Eligible population—The benefit package targets the population of children, aged 3 to 10 years, at risk of experiencing dental caries in their primary dentition.
- p Service modifier—Based upon the findings of the 1986-87 National Survey of Dental Caries in U.S. School Children, the mean number of decayed (unrestored) primary tooth surfaces requiring restoration was 1.1 tooth surfaces. The mean decayed and filled tooth surfaces score (dfs) for children aged 5-9 years was reported as 3.9 surfaces (the decayed component was 28 percent).¹⁹
- q Eligible population—The benefit package targets the population of children and adolescents, aged 6 to 18 years, at risk of experiencing dental caries in their permanent dentition.
- r Service modifier—Based upon the findings of the 1986-87 National Survey of Dental Caries in U.S. School Children, the mean number of decayed (unrestored) permanent tooth surfaces requiring restoration was 0.4 of a surface. The mean decayed, missing, and filled tooth surface score (DMFS) for children and aged 5-17 years was reported as 3.07 surfaces (the decayed component comprised 13.4 percent).¹⁹
- s Service modifier—Based upon the findings of the 1985-86 National Survey of Oral Health in U.S. Employed Adults and Seniors, the mean number of decayed (unrestored) coronal surfaces for employed adults aged 18 to 64+ was 1.3 surfaces. The mean decayed and filled coronal surfaces score (DFS) was reported as 23.2 surfaces (the decayed component comprised 5.6 percent).¹⁸
- t Service modifier—Based upon the findings of the 1985-86 National Survey of Oral Health in U.S. Employed Adults and Seniors, the mean number of decayed (unrestored) root tooth surfaces for employed adults aged 18 to 64+ was 0.4 of a surface. The mean decayed and filled root surfaces was reported as 0.76 of a surface (the decayed component comprised 53.5 percent of the DFS score).¹⁸
- u Service modifier—Based upon the findings of the 1985-86 National Survey of Oral Health in U.S. Employed Adults and Seniors, the mean number of decayed (unrestored) coronal surfaces for seniors aged 65+ was 1.54 surfaces. The mean decayed and filled coronal surfaces score was reported as 20.4 surfaces (the decayed component comprised 7.6 percent of the DFS score).¹⁸
- v Service modifier—Based upon the findings of the 1985-86 National Survey of Oral Health in U.S. Employed Adults and Seniors, the mean number of decayed (unrestored) tooth surfaces for seniors aged 65+ was 1.46 surfaces. The mean decayed and filled root surfaces score was reported as 3.17 surfaces (the decayed component comprised 46.1 percent of the DFS score).¹⁸
- w Service modifier—Based upon the findings of the 1986-87 National Survey of Dental Caries in U.S. School Children, 10 percent of children and adolescents were estimated to require dental scaling services beyond the "routine oral prophylaxis."
- x Service modifier—Based upon the findings of the 1985-86 National Survey of Oral Health in U.S. Employed Adults and Seniors, 53.7 percent of employed adults aged 18 to 64+ were reported with findings of subgingival calculus.¹⁸
- y Service modifier—Based upon the findings of the 1985-86 National Survey of Oral Health in U.S. Employed Adults and Seniors, 65.6 percent of seniors aged 65+ years were reported with findings of subgingival calculus.¹⁸

**TABLE V. Estimated Cost of Oral Health Benefits Package
(Implementation of the Various Clusters of Oral Health Services)**

Target Population	Oral Health Benefits Package (Estimated Cost of Implementation & per capita costs) ^a		
	Cluster "A" Services (\$134 per capita)	Cluster "B" Services (\$74 per capita)	Cluster "C" Services (\$35 per capita)
Total U.S. Population ^a (268.1 million)	\$34.9 billion	\$19.2 billion	\$ 9.1 billion
Dental Uninsured Population ^a (160 million)	\$21.5 billion	\$11.8 billion	\$ 5.6 billion
Population in Poverty (200 % of Federal Poverty Level) ^a (Estimated 74 million)	\$ 9.9 billion	\$ 5.5 billion	\$ 2.6 billion
Population in Poverty (150 % of Federal Poverty Level) ^a (Estimated 54 million)	\$ 7.2 billion	\$ 4.0 billion	\$ 1.9 billion
Population in Poverty (100 % of Federal Poverty Level) ^a (Estimated 34.5 million)	\$ 4.6 billion	\$ 2.5 billion	\$ 1.2 billion

Footnotes:

^a Based on 1995 U.S. population estimates.^b

^b Median dental fees obtained from 1985 American Dental Association national survey of general dental practitioners^c adjusted for inflation to 1992 dollars.

^c Based on 1992 U.S. population estimates.

- (2) **Oral Health Benefits Package -- Cluster "B" Services:**
(Primary Preventive, Acute Emergency, and Early Intervention Services for Children and Adolescents & Primary Preventive and Acute Emergency Services for Adults)

Cluster "B" services (TABLE VII) represents a lower cost alternative. Services for children are identical to those in cluster "A", but only acute emergency and preventive services are extended to adults.

At an annual per capita cost of \$74, the estimated annual cost of implementing this cluster of services for the entire U.S. population is \$19.2 billion (50 percent of the 1992 total expenditure for dental services in the U.S.), and \$11.8 billion for the dental uninsured population (TABLE V).

Although this package would have a positive impact on oral health, attainment of the oral health objectives of *Healthy People 2000* for adults and seniors would be unlikely by the year 2000.

TABLE VII. Oral Health Benefits Package -- Cluster "B" Services
 Primary Preventive, Acute Emergency and Early Intervention Services Targeted for Children & Adolescents
 Primary Preventive and Acute Emergency Services Targeted for Adults & Seniors

Basic Oral Health Services <i>Primary Prevention Services</i> <i>Acute Emergency Services</i> <i>Early Intervention Services</i>	Healthy People 2000 <i>Relevant</i> <i>Oral Health Objectives</i>	Target Population <i>Children & Adolescents (2-18 yrs.)</i> <i>Adults (19-64 yrs.)</i> <i>Seniors (65+ yrs.)</i>
Oral Health Assessment • Oral Examination (<i>Initial exam</i>) • Oral Examination (<i>Periodic exam</i>) • Dental Radiographs (<i>2 bitewings</i>)	Objective 13.07 Objective 13.11 Objective 13.12 Objective 13.13 Objective 13.14 Objective 13.16	Children & Adolescents
		Adults & Seniors
Dental Sealants	Objective 13.01 Objective 13.08	Children & Adolescents (8 and 14 yrs.)
Professionally-Applied Topical Fluorides	Objective 13.01 Objective 13.10	Children & Adolescents (Non-Fluoridated Areas)
		Children & Adolescents (High Risk -- Fluoridated Areas)
		Adults
Oral Prophylaxis (<i>Dental Cleaning</i>)	Objective 13.05	Seniors
		Children & Adolescents
Fluoride Supplements (<i>Daily Supplements</i>)	Objective 13.01 Objective 13.10	Adults & Seniors
Acute Emergency Dental Services (<i>Relief of acute pain and infection</i>)	Objective 13.02 Objective 13.13	Children (13 yrs. and under)
		Children & Adolescents
Dental Restorative Services (<i>Dental fillings</i>)	Objective 13.02	Adults & Seniors
		Children (2 to 10 yrs.) (Primary Teeth)
Periodontal Maintenance Services (<i>Dental scaling and root planing</i>)	Objective 13.12	Children & Adolescents (6 to 10 yrs.) (Permanent Teeth)
		Children & Adolescents

STATEMENT OF

THE AMERICAN DIETETIC ASSOCIATION

Chairman Waxman and Distinguished Members of the Subcommittee:

Thank you for the opportunity to comment on the standard benefits package provisions in health care legislation pending before your Subcommittee. We respectfully request that our comments be included in the Subcommittee's public hearing record.

It is well understood that nutrition plays a key role in preventing disease. Surveys of the American public show that people know that "eating right" prevents heart disease, diabetes, high blood pressure, and cancer. In contrast, little is known about the vital role medical nutrition therapy plays in treating disease.

For example, medical nutrition therapy is key in the treatment of:

- Cancer, in which nutrition therapy helps prevent the weight loss associated with cancer treatments, thereby increasing patient responsiveness to treatment, and enhancing patient tolerance of chemotherapy and radiation therapy;
- Heart disease, for which a specialized diet and exercise program helps reduce serious risk of further damage to the cardiovascular system and heart, thereby avoiding expensive surgery;
- Kidney (renal) disease, for which reduced liquid, protein, potassium and sodium intake, along with adequate caloric intake, can delay and reduce the need for dialysis;
- Diabetes, for which aggressive nutrition counseling, combined with frequent monitoring of blood sugar levels, prevents the need for insulin (for individuals with Type II diabetes) and reduces the occurrence of diabetes-related health problems;
- AIDS, where maintaining body weight and scientifically pursuing nutrition evaluation allows patients to more successfully combat opportunistic infections, prevent complications and live longer, more productive lives;
- Prenatal Care, for pregnant women at high risk of premature labor or other complications, where aggressive dietary therapy can achieve a balanced nutritional status and appropriate weight gain which reduces the incidence of cesarean section and low-birth weight;
- Pediatric Care, in which infants suffering from failure to thrive syndrome have lower hospital utilization when progressive nutrition therapy is applied; and
- Geriatric Care, for elderly home health and nursing home patients whose conditions make digesting and ingesting difficult, and specialized nutrition therapy can help prevent or treat complications like decubiti (bed sores) when they are able to maintain their nutritional status.

Medical nutrition therapy is further defined in the attachment.

MEDICAL NUTRITION THERAPY IS RARELY COVERED BY HEALTH INSURANCE

Health insurance plans seldom cover medical nutrition therapy. If they do, it often requires extensive requests, vigorous follow-up, documentation of medical necessity and personal pleas by the patient, physician and dietitian.

Health insurance plans typically follow the coverage rules adopted by the Medicare program created in 1965, well before the major advances in medical nutrition science that the program has never been updated to reflect. Medicare covers medical nutrition therapy only when patients are hospitalized and the hospital chooses to provide this service as part of its overall inpatient treatment plan. Medical nutrition therapy is generally not covered on an outpatient or ambulatory basis, the cost-effective setting for its provision.

The vast majority of non-hospitalized patients must pay for medical nutrition therapy out of their own pockets. Those who cannot pay for the services of a registered dietitian or qualified nutritionist are more likely to be hospitalized or have surgery to treat their conditions. Furthermore, physicians are less likely to recommend or prescribe medical nutrition therapy because it is not a covered benefit in the vast majority of health insurance plans.

MEDICAL NUTRITION THERAPY SAVES MONEY BY PREVENTING SURGERY AND HOSPITALIZATIONS

THE MONEY SAVED CAN BE USED TO FUND THIS NATION'S HEALTH CARE SYSTEM

Our current health care system spends millions of dollars needlessly because nutrition therapy is NOT routinely covered and provided when medically necessary. Research shows that **for every \$1 spent on medical nutrition therapy over \$3 are saved** in later medical care costs. (Note: This represents the **minimum** savings from over 450 actual case studies collected by ADA members over the past six months. Savings frequently ranged up to \$600 saved for every \$1 spent on medical nutrition therapy.)

To achieve the savings in hospital and treatment costs which medical nutrition therapy offers, health coverage must encourage the provision of these services before complications or disease progression occurs. Medical nutrition therapy must be accessible to patients in:

- ambulatory and outpatient treatment settings;

- home health care treatment settings;
- long term care facilities; and
- inpatient treatment settings.

Providing comprehensive nutrition therapy coverage for all patients with conditions or illnesses for which nutrition services are recommended would require approximately \$638 million in new spending for coverage of the ambulatory and outpatient treatment, the setting for which coverage is currently not provided. This investment in outpatient and ambulatory care medical nutrition therapy would prevent hospitalizations and reduce treatment for disease progression, **saving almost \$2 billion in health costs.** (Source: Report prepared by George J. Nielson, *Technical Report, Analysis of Costs Associated with Clinical Nutrition Services*, June 1993.)

MEDICAL NUTRITION THERAPY IN HEALTH CARE REFORM LEGISLATION

ADA urges you to support coverage for medical nutrition therapy in the standard benefit package. Almost 17 million people are treated each year for conditions or diseases that respond to medical nutrition therapy. These individuals should be eligible for medical nutrition therapy upon the recommendation of their primary care provider when medically appropriate and necessary. This coverage would produce net health care cost savings by preventing surgeries and hospitalizations.

The Health Security Act (H.R. 3600), introduced at the request of the Administration, marks a major breakthrough in the recognition of the value of nutrition in health care. The Health Security Act includes several provisions related to the standard benefit package:

- The Administration's bill intends to cover medical nutrition therapy as a basic benefit in "health professional services."
- Clinical preventive services specifically include nutrition counseling. This is in line with the recommendation of the US Preventive Services Task Force in its *Guide to Clinical Preventive Services: An Assessment of the Effectiveness of 169 Interventions*.
- Nutrition counseling is singled out as an example of health education and training that health plans are allowed to cover.
- Home infusion therapy—the administration of drugs or nutrients through a tube or intravenously for those unable to swallow or digest—is covered.

We applaud the above proposal for its recognition of the importance of medical nutrition service to improve the health of the nation and to lower health care costs.

However, ADA recognizes that several health care reform proposals in addition to President Clinton's plan are before this Subcommittee for consideration. Several do not specify a standard benefit package, and propose to establish a national health board outside

Congress to do so. We want to ensure that coverage of medical nutrition therapy is not ignored or forgotten as it has been until this point.

If Congress decides to define the standard benefit package in legislation, ADA requests inclusion of medical nutrition therapy when medically necessary and appropriate upon the referral of a primary care provider.

On the other hand, if Congress establishes a Health Care Standards Commission or other form of national health board to recommend a benefit package, ADA urges that criteria be established in health care legislation to ensure that insurance coverage will keep pace with scientific medical advancements that offer cost-effective, efficacious treatment -- criteria that require coverage of treatment recommended by practice protocols and outcomes research. Medical nutrition therapy, which has advanced so rapidly over the last decade, would then have a fair opportunity to be covered when medically appropriate.

CONCLUSIONS

Despite the overwhelming evidence that professionally delivered medical nutrition therapy results in more cost effective and quality health care, treatment is received by only a portion of the 17 million patients per year who are at risk. The reason is that current Medicare reimbursement policy—which many insurers copy—discourages its use.

A federal problem requires a federal solution.

It is critical that any health care legislation approved by Congress discontinue the discriminatory treatment for medical nutrition therapy in present health insurance plans. ADA strongly urges this Subcommittee to ensure that the final bill acknowledges the scientific advancements of medical nutrition science by providing coverage of medical nutrition therapy, or if the benefit package is developed outside Congress, by establishing clear criteria regarding its eligibility for coverage.

We look forward to working with this Subcommittee in the development of important health care legislation and would be pleased to respond to any questions you may have.

Attachment

MEDICAL NUTRITION THERAPY IN DISEASE TREATMENT

Based on clinical research and experience, medical professionals—physicians, dietitians, and nurses—identify specific nutrition services that may be necessary to treat illness and injury. Nutrition assessment and nutrition therapy, the two key components of medical nutrition therapy, involve:

Assessment of the nutritional status of patients with a condition, illness or injury that places them at high risk of malnutrition. The assessment includes review and analysis of medical and diet history, blood chemistry laboratory values, and anthropometric measurements to determine nutritional status and therapeutic modalities.

Therapy ranging from diet modification to administration of specialized nutrition support, which includes intravenous medical nutrition products as determined necessary to manage a condition or treat illness or injury. Components of nutrition therapy are:

- **Diet Modification and Counseling:** For many patients, key components of nutrition therapy are intervention and counseling leading to the development of a personal diet plan to be followed to achieve nutrition goals—such as reduced blood sugar levels, reduced protein intake, or increased caloric intake. For example, patients with diabetes can often control their blood sugar levels without medications or with reduced levels of medication after counseling and diet modification intervention from a registered dietitian.
- **Specialized Nutrition Support:** Professional assessment may identify special nutrition needs that must be met by specialized nutrient supplementation using medical foods, by enteral nutrition delivered via tube, or by parenteral nutrition delivered via intravenous infusion. For example:

—Supplementation with medical foods would be appropriate for patients with pressure ulcers, chronic obstructive pulmonary disease, and muscular dystrophy; for surgical patients with low biochemical values; and for patients unable to digest adequate nutrients through food intake.

—Enteral nutrition delivered via tube feedings would be appropriate for patients unable to ingest or digest, such as is the case for some stroke victims and for patients with head or neck injuries.

—Parenteral nutrition delivered via intravenous infusion would be appropriate for patients with severe burn injuries—where hydration, electrolyte balances, and adequate caloric intake are vital to recovery and to preventing secondary infections—and for patients with gastrointestinal disorders that prevent normal absorption of nutrients.

STATEMENT OF AMERICAN GROUP PSYCHOTHERAPY ASSOCIATION

December 6, 1993

Mr. Chairman, the American Group Psychotherapy Association (AGPA) is a national training and standard-setting society representing thirty affiliate regional organizations and over 4000 professionals, including psychiatrists, psychologists, and social workers. We are pleased to testify before your committee in the hope of contributing usefully to your deliberations on the inclusion of mental health care as proposed in the PRESIDENT'S HEALTH SECURITY ACT.

Based on a compelling body of empirical evidence, it has been established that group psychotherapy, either alone or in combination with other clinically indicated treatment modalities, provides clinically effective and cost-effective treatment of a broad range of psychological problems and disorders.

Before summarizing these findings the AGPA wishes to emphasize that it joins its mental health colleagues in expressing its firm conviction that patients suffering from psychological disorders and problems require, and should receive, full protections and benefits comparable to those provided to the physically afflicted and disordered.

That group psychotherapy enjoys a cost-effective advantage over alternate psychological therapies becomes self-evident when one considers the following: 1. it makes more efficient use of the skilled psychotherapist's time and energies, e.g., a single

group therapist is able simultaneously to treat 6-10 patients, 2. the average fee charged each group patient is substantially reduced, and 3. the prorated direct and indirect costs to the sponsoring treatment center/clinic are also lower.

Over the past 15 years reviews of a large number of well-controlled studies have been reported, which compare the relative efficacy of group and individual therapy when skillfully applied to comparable patient samples. The favorable group therapy findings have been remarkably consistent.

1. Patients treated in either group or individual psychotherapy are significantly more benefited -- statistically and clinically -- than are comparable patients in the treatment control groups.
2. Over 200 comparisons of the relative effectiveness of outpatient group and individual therapy with adults and adolescents only rarely reveal the existence of statistically significant differences.
3. In those instances where significant differences were found between group and individual therapy they preponderantly favored group therapy.
4. From the point of view of clinicians and clinic administrators there is now ample evidence to justify giving priority to the expanded use of group psychotherapy.
5. The AGPA, on behalf of its uniquely broad mental health constituency, concludes that in terms of its demonstrated therapeutic efficacy and cost-effectiveness, group psychotherapy has much to commend it to psychotherapists, a broad spectrum of mental health patients and, of course, to health care legislators and third-party payers.



**TESTIMONY OF THE
AMERICAN OCCUPATIONAL THERAPY ASSOCIATION
TO THE
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
U.S. HOUSE OF REPRESENTATIVES**

DECEMBER 8, 1993

Chairman Waxman, Members of the Committee:

The American Occupational Therapy Association (AOTA) appreciates the opportunity to submit testimony to the House Subcommittee on Health and the Environment to share our views on the proposed mental health care benefit package in President Clinton's health care reform plan.

The AOTA, established in 1917, represents the professional interests of 47,000 occupational therapists, occupational therapy assistants and students of occupational therapy. As health and rehabilitation professionals, our members provide services to those disabled by illness, injury or psychological or developmental impairment. A registered occupational therapist or a certified occupational therapy assistant (COTA) must be a graduate of an educational program accredited jointly by the American Medical Association and the American Occupational Therapy Association, complete supervised field work and pass a national certification examination. Course work for both therapists and assistants includes the biological sciences and psychosocial development.

The profession of occupational therapy has its roots in the field of mental health. Occupational therapists help individuals with mental health disorders to develop the skills necessary for independent, productive living. Particular emphasis is given to assisting the individual in the transition from hospital to the community and in teaching adaptive skills and coping strategies to help prevent rehospitalization. Occupational therapists provide services in acute psychiatric admission units in general hospitals, private psychiatric hospitals, state psychiatric hospitals, Veterans Administration medical centers, and crisis centers. Included among the community-based mental health care settings where occupational therapists are employed, or provide consultation, are partial hospitalization and day treatment programs as part of outpatient psychiatric clinics, community psychiatric rehabilitation programs (also known as psychosocial rehabilitation programs), community mental health centers, home health agencies, nursing homes, and group and private homes.

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We believe the President deserves great credit for making reform of the nation's health care system a centerpiece of his legislative agenda and for advancing a comprehensive proposal to achieve that goal. We applaud the Administration's efforts to provide universal insurance coverage for a comprehensive range of health benefits. We support the recommendations for insurance industry reform, which would eliminate highly discriminatory practices such as pre-existing condition exclusions, a critically important reform for individuals and families who experience chronic conditions and disabilities. The new initiatives in long term care services and supports for those with severe disabilities are major steps toward addressing the needs of some of the most vulnerable members of our society.

The President's initiative presents the opportunity to reform our health care system in a comprehensive manner to improve the availability of health care to all Americans. Comprehensive reform can enable us to examine health care with a wide lens, encompassing a view of health which addresses the needs of an individual to lead a full and productive life. It offers the opportunity to solidify gains made possible by new knowledge, and to refine and redirect trends such as managed care to better meet the health care needs of Americans. Our goals in health reform must look to larger issues: to more effectively and productively use our human and financial resources, to enhance each individual's contribution to our society, and to maintain the quality and innovativeness of health care in America. In many respects the President's proposal holds great promise to meet these challenges. However, a comprehensive revamping of health financing and delivery brings with it the potential for unintended consequences and adverse effects.

AOTA believes the President's proposal does not sufficiently meet the needs of individuals with mental illness because it incorporates benefit limits that do not mirror the treatment accorded physical illness under the plan. The benefit structure applies stringent limits on alternatives to inpatient care, particularly limiting intensive non-residential treatment, as well as restricts who can receive mental health care. We are concerned that the mental health benefit of the President's plan undermines a growing effort in our nation to treat individuals with mental health care needs appropriately and to take their needs seriously. Waiting until the year 2001 to provide mental health care on par with physical health care interrupts an emerging comprehensive and flexible system of mental health care where the individual is served in the least restrictive, often more appropriate and less costly, alternative to traditional inpatient care. Implementation of an antiquated system of arbitrary limits on mental health care during this interim period is, indeed, a step backwards from this changing system, and serves to perpetuate inaccurate assumptions and stigmatization toward mental health problems.

Testimony submitted to the Committee by a mental health coalition of 38 organizations, including AOTA, points out defects of the interim benefit plan as well as other shortcomings in the mental health benefit. It is ironic that the President's plan represents a mental health benefit package that is less than the average plan now offered

by many health insurance plans. We would specifically like to address our comments to the seriousness of short-changing the availability of alternative services to inpatient care, and to the importance and cost effectiveness of providing a full range of services.

THE BENEFIT MUST INDIVIDUALIZE CARE AND CONTINUE ALTERNATIVES

Over the past 20 years, the range of intensive nonresidential services - partial hospitalization, day treatment, psychiatric rehabilitation, community mental health care programs, home-based care, etc. - have become an integral part of our nation's mental health care system. Alternatives to inpatient care emerged primarily for three reasons: as part of a movement to find more effective alternatives to inpatient acute and residential care, as a means to control high utilization rates of emergency rooms and repeated hospitalizations, and in response to low functioning capabilities of individual with mental illness. These services are now recognized as an important component of the mental health care delivery system as both more appropriate alternatives to inpatient care and as transition services for a hospitalized patient. Stephen White, vice president of Charter Medical Corp., in recognizing that hospitalization may no longer be the only appropriate treatment, says that "(p)sychediatric care should be matched to the specific needs of each patient,...and recognize that a comprehensive mental health provider has to offer an array of services..." (Special Report, Business and Health, "Psychiatric Care Delivery is Improving").

An important part, and in some cases, the most important part, of an individual's mental health care treatment is help with coping and functioning in society. Pharmacological treatment alone is not sufficient. Occupational therapists work with behaviors that interfere with an individual's functional independence. Without this assistance, individuals often inappropriately end up back in the hospital. The National Institute of Mental Health (NIMH) reports much lower recidivism rates when a combined set of outpatient services are provided to the individual (Health Care Reform for Americans with Severe Mental Illness: Report of the National Advisory Mental Health Council, Rockville, Maryland: National Institute of Mental Health, 1993).

Intensive non-residential services are designed specifically to help the individual with a mental illness learn to manage the symptoms of the illness in a normal setting. One of the cognitive disabilities often seen in an individual with a severe mental illness is difficulty in generalizing learning from one situation to another. The functional limitations frequently seen in an individual with a mental illness may include deficits in daily living, impaired social interactions, ineffective problem solving, a diminished ability to maintain relationships, and a marked impairment in role functioning. Assessment and interventions provided by an occupational therapist in these settings address the underlying factors (performance components) that contribute to or interfere with desired functional outcomes in the areas of sensory motor skills, cognitive skills and psychosocial skills. A client with schizophrenia may have cognitive deficits that interfere with his or her ability to organize, sequence through the steps of an activity, and problem solve

difficulties encountered. The occupational therapist would assess both the client and the home or work environment to determine what was interfering with the client's ability to carry out activities safely and would provide an intervention of environmental supports or compensatory skills necessary to safely and competently perform the needed activity.

As the 38-member mental health coalition reported in their testimony, despite the fact that intensive non-residential care has become an important component of mental health care in rehabilitating individuals with serious mental illness, the President's health care plan makes the first 60 days of these services available in the interim plan only as a trade off to inpatient care. Consequently individuals are forced to relinquish their inpatient safety net to utilize community-based intensive care. This places an undue burden on the individual and actually gives the individual no real choice at all to choose clinically appropriate care.

To use the second sixty days, an individual must pay both a one-day deductible and 50% copayment. Even in the low copay plans, using the 60 days will cost the individual \$1500, none of which counts toward the out-of-pocket limit.

As the mental health coalition reports, the combination of trade-offs and high copayment requirements negates the value of this innovative approach as an alternative to high cost inpatient care as a means of serving the individual in the least restrictive environment. AOTA joins the mental health coalition in urging the restoration of intensive nonresidential care to an independent benefit, not requiring a trade-off or oppressive copayments.

CLINICAL AND COST-EFFECTIVENESS OF ALTERNATIVE CARE RECOGNIZED

The NIMH research reveals that most mental disorders can be appropriately treated without hospitalization. Intensive non-residential care such as partial hospitalization and psychiatric rehabilitation has significantly reduced hospitalization and improved an individual's level of functioning and quality of life. NIMH reports on studies that show these treatments have been successful with patients with manic depression, schizophrenia, and anxiety disorders (NIMH, 1993).

Evidence of these successes is the fact that both self-insured health care plans and private psychiatric hospitals have changed their mental health benefits plan to offer alternatives to inpatient care. A review of the private psychiatric hospitals who are members of the National Association of Psychiatric Health Systems (NAPHS) demonstrates these changes in the mental health care delivery system. The number of NAPHS psychiatric hospitals offering alternatives to inpatient care have steadily increased and the number of new patients entering partial care programs jumped from approximately 172,000 in 1980 to 293,000 in 1988. Data from a 1992 survey on the past three-years of activities of these hospitals showed 79% of the private psychiatric hospitals

offered occupational therapy services as part of their care (Special Report, Business and Health).

Outcomes research collected by the International Association of Psychosocial Rehabilitation Services (IAPSRs) includes a review of 35 studies by Dion and Anthony (1987) showing that psychiatric rehabilitation interventions reduced hospital recidivism and positively affected employment, skill development, client satisfaction, and the amount of time spent in the community. Additionally, they found many studies showing the reduction of hospital utilization as a result of psychiatric rehabilitation and case management services (Bond et. al, 1984; Bond, 1988; Dincin and Witheridge, 1982; Fairweather and Fergus, 1988; Hammaker, 1983).

Klyczek and Mann (1986) found that clients with schizophrenia receiving primarily activity therapy - as opposed to verbal therapy that focuses on less tangible change such as insight - achieved a much greater reduction in symptomatology, and this symptomatology translates into increased levels of independent functioning in community living skills. These clients were also hospitalized for shorter periods of time than clients receiving primarily verbal therapy.

In addition to clinical effectiveness, IAPSRs also reviewed studies regarding the cost effectiveness of alternative care. Cost savings were evident by lower hospitalization rates, reduced utilization of community treatment by the individual over time, and increased employment. In studies regarding schizophrenia, Goldberg (1991) found community care was more cost effective than hospital care.

Mental health care is relatively inexpensive compared to other health care services. Mental health care costs have remained relatively constant over the past 15 years, making up approximately 10% of total health care treatment (NIMH, 1993). The cost to society of not providing an adequate mental health benefit will be much higher in unemployment, welfare, homelessness, etc. Individuals with untreated mental illness consume almost twice as much medical care as the average individual. (Borus, et. al., 1985.)

MANAGED CARE

The mental health community has had experience with both good and bad managed care practices. AOTA supports good managed care practices as an alternative to arbitrary and discriminatory limits on mental health care. A 1992 Hay/Huggins (a Washington-based actuarial firm) report on psychiatric benefits, managed care organizations have claimed savings between 15% and 40% due to alternative care, compared with traditional approaches (Special Report, Business and Health). Strong quality assurance mechanisms, developed by a comprehensive range of health professionals, as well as strong grievance procedures, is critical to ensuring quality care while attempting to contain costs.

AOTA has endorsed the managed care safeguards articulated by the Consortium for Citizens with Disabilities (CCD) Health Task Force, a copy of which is attached for the Committee's review. Specifically, these recommendations address problems such as financial incentives used to restrict access, the lack of an array of comprehensive services needed, the lack of quality assurance mechanisms and effective grievance policies to ensure access to appropriate care; and the lack of expertise and training on the part of gatekeepers to determine the needs of individuals, particularly the specialized mental health and disability needs of individuals, and access to specialists and specialty care.

Creating a gatekeeping process that can ensure individuals have access to appropriate care, whether it be mental health or other specialty care, must recognize a single gatekeeper's limited expertise in these specialty areas. Managed care plans should not be permitted to arbitrarily select one health discipline to be the gatekeeper for all individuals, and in effect, control and possibly limit the range of services available. Information of health and mental health needs of individuals, as well as information on current and appropriate practices, must be sought from a variety of sources, including the health professional whose service is under review. A multidisciplinary team approach can be required where a combination of opinions are solicited, including the opinion of a specialist licensed and trained specifically to provide the service being evaluated.

AOTA hopes that the Committee and the U.S. House of Representatives will support a comprehensive system of mental health care subject to the same cost containment strategies as physical health care. We urge you to consider the research base which supports the need and cost effectiveness of intensive non-residential care, particularly as appropriate alternatives to inpatient care.

We look forward to working with you to develop a responsible mental health care plan for health care reform.

Consortium for Citizens with Disabilities

December, 1992

THE CONSORTIUM FOR CITIZENS WITH DISABILITIES HEALTH TASK FORCE

PROBLEMS AND SAFEGUARDS FOR PEOPLE WITH DISABILITIES IN MANAGED CARE

The CCD Health Task Force "Principles for Health Care Reform from a Disability Perspective" were developed to assess the ability of various major health care reform measures to meet the needs of people with disabilities. Since many reform proposals utilize some form of managed care, the CCD has applied these principles and identified a number of major problems in managed care systems.

This document identifies these problems and makes recommendations to improve the ability of managed care systems to better meet the needs of people with disabilities. The CCD believes that it is critical for health care policy makers to recognize that there are at least 43 million Americans with disabilities and a large number of others with special health care needs. This includes individuals of all ages with physical and mental impairments, conditions or disorders, that are severe, acute, or chronic and limit or impede their ability to function.

Problems with Recommendations for Improvement

- I. Managed care systems often include financial incentives to restrict access, limit or deny care, or provide poor quality care. This is especially detrimental to children and adults with disabilities and those with special health care needs.
 - A. Capitated managed care systems must have the flexibility necessary to permit primary care physicians to refer participants with disabilities to specialists without being financially penalized.
 - B. Primary care physicians in managed care plans must be adequately compensated and not placed at inordinate financial risk.
 - C. Methods for ensuring the financial solvency of managed care entities, particularly capitation models, must be considered. These may include financial solvency requirements for HMOs, mandatory reinsurance, state reinsurance for Medicaid managed care programs, stop-loss coverage, and mandatory capitalization requirements.
- II. Managed care systems often do not include the array of comprehensive health related services needed by children and adults with disabilities.
 - A. Managed care programs must offer a comprehensive benefits package that meets the needs of people with disabilities and special health care needs. This includes such basic benefits as prescription drugs, rehabilitation services, durable medical equipment, such as wheelchairs and other assistive technology, and mental health services.
 - B. Managed care programs must not include disincentives, financial or otherwise, to the provision of services in home and community-based settings when appropriate.
 - C. Specific services should be provided not only to treat acute and chronic conditions but also to promote and maintain health and optimum functioning and prevent deterioration and secondary complications.

- III. Managed care systems often have limited experience in providing comprehensive services to children and adults with disabilities because of a systemic emphasis on primary care. This leads to limited access to needed specialized services, delays in services, and a lack of continuity of care needed by children and adults with disabilities.
 - A. Managed care systems must offer people with disabilities and special health care needs the option of having a specialist as their "gatekeeper" in the system. This specialist would provide both necessary specialized care (at the specialized rate) and primary care (at the lower primary care reimbursement rate).
 - B. Managed care entities must have specific limits on waiting times for first appointments and for specialty referrals. To assure geographic accessibility of services, there must also be established standards on travel times and distances to both primary and specialized services.
 - C. Managed care systems must be structured to ensure continued, appropriate access to health and health-related services for children and adults with disabilities.
- IV. Managed care systems lack adequate quality assurance mechanisms, as well as effective grievance policies and procedures designed to ensure access to appropriate health services.
 - A. Managed care systems must provide participants with clear information on policies, procedures, and grievance mechanisms and must ensure consumer participation in the establishment of such procedures. All reviews must be conducted in a timely manner. An independent ombudsman program should be required.
 - B. Managed care systems should be required to provide health care service in accordance with nationally accepted prevention and treatment protocols, e.g. protocols for prenatal care, well-baby care, and childhood immunization schedules.
 - C. Managed care systems must have in place timely procedures for obtaining independent second opinions when covered benefits are denied for any reason, including a judgement that they are not "medically necessary" or when a consumer challenges the appropriateness of a proposed treatment. These second opinions must be considered in any grievance review.
 - D. Managed care systems must include the option to disenroll for those participants who are not receiving adequate and timely services.
 - E. Managed care programs must have strict quality assurance provisions that require internal and external audits by independent assessors and the results of these audits should be available to consumers to assist them in choosing a managed care program. Outcome reviews should be a component of this process.
 - F. Additional protections which must be included are satisfaction surveys of enrollees and disenrollees, including current and former providers.

For additional information contact: Co-Chairs of the CCD Health Task Force

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STATEMENT

of the

AMERICAN PHYSICAL THERAPY ASSOCIATION

INTRODUCTION

The American Physical Therapy Association (APTA), the national association representing over 60,000 physical therapists, physical therapist assistants, and students of physical therapy submits the following testimony relative to national health care reform and the benefits package.

Physical therapists are an integral part of the health care delivery system. Physical therapists help 900,000 individuals daily to restore health and alleviate pain. Working with people of all ages, physical therapists treat children in public schools who are disabled or need special attention, senior citizens in nursing homes suffering from arthritis or hip injury, patients in hospitals, athletes recovering from injury, employees of industrial plants injured at the work place, infants born of cocaine-addicted mothers and veterans coping with an amputated leg or paralysis. The benefits of rehabilitation and physical therapy services are well documented and services are covered in nearly all federal, state and private insurance plans. Physical therapy services are among the most cost effective health services because a limited course of physical therapy often shortens a hospital stay, prevents future injury, and improves health outcomes. Today's physical therapy profession serves a dynamic, comprehensive health care role in improving and maintaining the quality of life for millions of Americans.

The APTA shares the desire of the American public, political leaders and other health care providers to make quality health services more accessible and affordable for all Americans. APTA appreciates your continued dedication to the well-being of the many Americans who require physical therapy services. Thank you for the opportunity to provide this testimony and to show our willingness to work with you to achieve our mutual objectives.

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A key element to the success of health care reform is a comprehensive benefits package which provides consumers with incentives to prevent injury and illness and which provides security should these events occur.

According to the National Institute on Disability and Rehabilitation Research, Digest of Data on Persons with Disabilities: 1992, an estimated 40 million Americans live with some form of disability. Total direct costs, including health care expenditures, loss of productivity in the work force, and loss of wage-earning ability among other household members, are estimated at 6.5% of the GNP.

According to the U.S. Administration on Aging, there currently are nearly six million noninstitutionalized people over 65 who have physical impairments. With the aging of the population, the proportion of people at risk for disability will continue to climb.

The number of individuals with disabilities and the economic impact of their health problems will increase if appropriate prevention and rehabilitation programs are not introduced. Many primary and secondary disabilities are preventable and physical therapy already plays a critical role in reducing disability through prevention programs. For example, an estimated 5.2 million Americans are disabled by low back pain; half of these individuals are chronically disabled. Low back pain is the most common cause of disability among the population under age 45 years and the third most important cause in the population over 45 years of age. The majority of back injuries are job related among the working population. In 1986, the annual cost of compensable back pain was estimated at \$11.6 billion. Physical therapy is widely viewed as the most cost effective and best type of care for preventing and alleviating the effects of low back pain.

The cost effectiveness of physical therapy programs which prevent disability in the work site is well documented. According to the Washington Business Group on health, physical therapist intervention resulted

in the following savings for some major corporate employers:

Coors.....\$604,000 total net savings;

Potomac Electric....\$500,000 yearly;

Lockheed.....\$105,000 yearly;

Westmoreland Coal...\$ 53,130 yearly; and

Mississippi Power...\$ 45,000 yearly.

Physical therapy services are among the most cost effective health services because a limited course of physical therapy often shortens a hospital stay, prevents future injury, and improves health outcomes. A few examples drawn from current scientific literature support this assertion:

•Mackenzie and others note that the use of chest physical therapy techniques reversed/prevented alveolar collapse and pneumonia for designated post-operative patients at risk for such.¹

•In a randomized controlled trial of physical therapy provided for post-operative pulmonary complications, Morran and others state: "Routine prophylactic postoperative chest physical therapy decreased significantly the frequency of chest infection."²

•Hayes has identified that the early use of physical therapy with stroke patients (within 72 hours of onset) increased overall function including mobility and decreased the need for future

¹Mackenzie CF, Shin B, McAsken TC. Chest Physiotherapy: The effect on Arterial Oxygenation. *Anesth Analg* 57: 28-30, 1978.

²Morran CG, Finlay IG, Mathieson M, McKay AJ, Wilson N, McArdle CS: Randomized Controlled Trial of Physiotherapy for Post-operative Pulmonary Complications. *BR J Anaesth* 55: 1113-1117, 1983.

hospitalization.³

•Rutherford, while noting that "osteoporosis is currently the major cause of bone fractures in post menopausal women and older people and is associated with a high personal and medical cost," found that exercise condition, a physical therapy procedure, prevents or reverses the effects of their debilitation condition and thus contributes significantly to the reduction of falls in this particular population.⁴

•Ryden and others report on a hospital-based physical therapy back care program that resulted in a one-year \$200,000 decrease in back care costs and a reduction of incidents per thousand employees from 31 to 15.⁵

•A retrospective audit of patients post-myocardial infarction in Great Britain showed that patients who underwent cardiac rehabilitation, including physical therapy procedures such as exercise conditioning and education, spent less than half the amount of time in a hospital as a result of readmissions than did patients who received only routine care.⁶

As a supplement to these examples, the APTA has a bibliography of articles that address the effectiveness of

³Hayes SH, Carroll SR. Early Intervention Care in the Acute Stroke Patient. *Arch Phys Med Rehab*, 67: 319-321, 1986.

⁴Rutherford Om. The Role of Exercise in Prevention of Osteoporosis. *Physiotherapy*, 76: 522-525, 1990.

⁵Ryden L Alicia, PT, MPH, et al. Benefits of a Back and Light Duty Health Promotion Program In a Hospital Setting. *Journal of Community Health*, Vol 13, No. 4, Winter, 1988.

⁶Kehl P. A Retrospective Look at the Effects of Cardiac Rehabilitation - Post Myocardial Infarction. *Physiotherapy* 77, 77-80, 1991.

physical therapy intervention across a spectrum of conditions and as a means of preventing initial trauma, or deterioration or reoccurrence following an initial trauma. Please contact the government affairs department for more information.

The APTA believes that based on the experiences of major employers and insurers, it is possible to define affordable limits on a package of preventive physical therapy services that will save many times the cost of such services.

MAKE UP OF PHYSICAL THERAPY BENEFITS IN THE CORE BENEFITS PACKAGE

When fully developed, any basic benefits package should cover:

- The diagnosis, treatment, and preventive services provided by physical therapists in both inpatient settings (hospitals, skilled nursing facilities, and through home health agencies) and outpatient settings (physical therapists' offices, patients' homes, rehabilitation agencies, comprehensive outpatient rehabilitation facilities, hospital outpatients departments, and nursing homes).

Arbitrary caps and limits on care should be avoided in the development of a package. Such limits on physical therapy services harm members of society who greatly need our care. Once an individual who suffers from a stroke, head injury or other extensive disability reaches an artificial cap, that person is sent back into the ranks of the uninsured because they do not carry insurance to meet their medical needs. Rather, care should be based on medical necessity with review for the effectiveness of therapy, as is currently done in most settings under the Medicare program.

- Assistive technology and devices to allow individuals to live functional, independent lives.

Examples of equipment include canes, walkers, wheelchairs, and prosthetic and orthotic devices.

•Prevention and wellness programs provided by physical therapists, including but not limited to:

- 1) prenatal instruction for posture alignment and strengthening;
- 2) weightbearing and safe conditioning exercise programs for the prevention of osteoporosis;
- 3) industrial disability programs to prevent job related disabilities including repetitive motion injuries for assembly line workers;
- 4) cardiac and pulmonary disease wellness and rehabilitation programs;
- 5) high-risk infant and young child screenings; and
- 6) school based scoliosis screenings. Physical therapists teach prevention and wellness in many settings including: private offices, the worksite, retirement centers, schools, and group homes.

PRESIDENT CLINTON'S BENEFITS PACKAGE

President Clinton's health care plan identifies a broad package of basic guaranteed benefits; however, there are several areas which must be refined. For example, the area of care for chronic or congenital conditions does not appear to be adequately addressed. While coverage is stressed for conditions arising out of illness or injuries, there are life-long diseases, such as cystic fibrosis, which can have decreased morbidity or mortality with the appropriate interventions. We urge that these conditions be covered as well.

Similarly, the President's plan would continue coverage so long as recovery is documented. Important as this is, it fails to recognize the value of maintaining patients who have plateaued at a maximum level of function. If these patients are denied access to continuing care, they revert to a condition where acute and

more costly interventions are required.

Preventive services in general are less than adequately delineated. Despite a well-defined package of clinical preventive services, the plan does not focus on preventive approaches to musculo-skeletal conditions determined through such procedures as scoliosis screening or posture evaluations. Nor does the plan identify the cardiac and pulmonary preventive care provided by physical therapists and others through exercise training/conditioning and consumer education. Preventive care must be emphasized much more strongly.

CURRENT DELIVERY OF PHYSICAL THERAPY SERVICES

Services of physical therapists should be a key component of any health care reform package for the following reasons:

1) PHYSICAL THERAPISTS ARE A KEY COMPONENT OF THE HEALTH CARE DELIVERY SYSTEM PROVIDING SERVICES TO A WIDE RANGE OF PATIENTS IN A MULTITUDE OF SETTINGS

Physical therapists' education and clinical experience uniquely prepare them to manage care related to functional improvement, to relieve pain, and to prevent the onset of disease and functional disability. Through evaluation, diagnosis and individualized treatment programs, physical therapists both treat existing problems and provide preventive health care for people with a variety of needs.

Physical therapist care, provided at the acute, rehabilitative or preventive stages, strives to achieve increased functional independence and decreased functional impairment. Through timely and appropriate intervention, the physical therapist frequently reduces the need for costlier forms of care such as surgery, as well as

shortens the length of institutional stays. Physical therapist preventive care forestalls or prevents the development of functional deterioration and the need for more intense care through hospitalization or extended care facilities.

2) PHYSICAL THERAPY SERVICES ARE COMPREHENSIVELY COVERED IN PUBLIC AND PRIVATE PROGRAMS

Both inpatient and outpatient physical therapy services are covered in almost all Federal and State as well as private insurance plans.

Physical therapists are an integral part of the health care delivery system. In addition to covering diagnostic and treatment services of a physical therapist and the assistive technology and devices our patients require to live functional, independent lives, we believe that the preventive services of physical therapists should also be included in a basic benefits package. Together, these benefits will greatly assist in the creation of a healthier and a more secure society.

We commend you for holding this hearing and look forward to working with the Subcommittee on reforming our health care system.

Testimony

of

The American Psychological Association

Chairman Waxman and distinguished Members of the subcommittee, the American Psychological Association, the largest membership association of psychologists with more than 118,000 members engaged in the study, research, and the practice of psychology, greatly appreciates the opportunity to submit this testimony to the Subcommittee on Health and the Environment for the record.

The APA thanks Chairman Waxman for his many years of leadership in addressing our nation's health care crisis, and we are grateful for the heroic efforts that Members of this subcommittee have taken to see that the mentally ill partake in the promise of national health care reform; the promise that they will receive the care which they need and deserve as human beings and as citizens of our nation. We look forward to assisting the Members of this subcommittee during your extensive and searching review of President Clinton's health care proposal and in your vital efforts to reform our country's health care system.

The APA commends President and Mrs. Clinton for the enormous leadership that they have shown in presenting to Congress a detailed health care plan and particularly for the attention that they have given to the needs of the mentally ill. The President's plan contains much to applaud: the promise of comprehensive health benefits that cannot be taken away for any reason; reform of the insurance market to end insurance industry practices which "game" the health system through pre-existing condition exclusions, adverse selection, discriminatory premium rating and other practices which protect profit margins while locking people out of health coverage; and, initiatives that promise access to health services regardless of geographic, socioeconomic, or cultural status or background.

While the President's plan offers much hope for the mentally ill, today we will focus on ways that Congress may improve the plan so that mentally ill persons may receive the care they need through the most cost-effective means. As psychologists, we are deeply and uniquely involved with the needs of the mentally ill and the system in which they presently receive care. The APA has developed a statement called "Principles for Mental Health and Psychological Services in Health Care Reform." As our principles statement attests, we believe the people of our nation should have access to a continuum of mental health services including: preventive, emergency, outpatient (including appropriate levels of psychotherapy, psychological rehabilitative, and neuropsychological) services, diagnostic testing and assessment, inpatient and residential treatment, prescription drugs, and additional services for children, adolescents, women, and other persons with special needs. Our principles statement outlines our belief that, by removing the inefficiencies in the current mental health delivery system, a continuum of quality mental health services may be offered cost-effectively. The APA respectfully submits our principles statement for the record as an attachment to this testimony.

Mental illness devastates the lives of those afflicted and drains our society and economy of needed resources. The comprehensive benefits package must cover mental health and substance abuse services.

The human suffering caused by mental illness and substance abuse addiction exact a tremendous toll on our nation. Right now, 15-18% of Americans, including 14 million children, suffer from a diagnosable mental disorder. 50-70% of visits to primary care physicians are for medical complaints that stem from psychological factors. In any one-month period, nearly eight million Americans suffer from depression, and as many as one-in-five Americans will suffer at least one

major episode of depression during their lifetimes. A random study of elderly residents in Medicaid facilities determined that nearly 80% of the residents had moderate to intense needs for mental health care.

Mental illness and substance abuse addiction lower our national productivity, costing our economy billions of dollars each year. As of 1990, mental illness cost society an estimated \$129.3 billion annually, about half of which was found attributable to lost productivity in the workplace. In 1990, the number of lost work days associated with major depression alone, cost our economy \$23 billion, and we now believe that minor depression, which affects more people, may account for 51% more disability days than major depression. A three year study of a large corporation concluded that 60% of employee absences were due to psychological problems.

Even when workers are not absent, mental illness decreases on-the-job productivity. Mental illness, including depression, can be as functionally disabling as a serious heart condition and more disabling than most other chronic physical illnesses such as lung or gastrointestinal problems, angina, hypertension, and even diabetes. We now believe that mental illness is the condition that most limits the ability to work, and mental illness is the third most limiting health condition in terms of performing major daily activities with only cancer and stroke being more debilitating.

Our society is terribly burdened by the cost of untreated mental illness and substance abuse addiction. Nearly 1/3 of our nation's homeless suffer a severe mental illness. A majority of the 30,000 suicides in this country each year may be attributed to a psychological or substance abuse disorder. The costs associated with the lost contribution to our nation due to the inability of so many of our people to receive appropriate and timely mental health care is unmeasurable but undoubtedly staggering.

The comprehensive benefits package must cover mental health and substance abuse services, because these services are effective, reduce the costs associated with physical illness, and increase economic productivity.

A wide array of outpatient and inpatient psychological treatment interventions are available and proven to effectively treat persons suffering from mental illness and substance abuse addiction. The treatment success rate of psychological interventions for several major mental disorders is impressive, surpassing many of the success rates for medical interventions. Psychological services successfully treat 70-90% of anxiety and stress disorders, 80% of both manic and depressive bipolar disorders, 70-90% of major and minor depression, 60-80% of the cases of substance abuse, and 60% of schizophrenia. Compare the effectiveness of these psychological interventions with two common medical interventions: angioplasty has a 41% treatment success rate and atherectomy, a 52% success rate. In the health care system, dollars directed towards psychological services buy successful outcomes for people suffering from mental illness.

Mental health and substance abuse treatments are cost-effective and reduce the costs associated with physical illness. Mental health costs have remained relatively constant over the last 20 years, constituting approximately 9-11% of direct treatment costs. Mental health and substance abuse treatments combined rank only 25th as a factor influencing health care cost increases.

In addition to cost stability, mental health services reduce the costs associated with the treatment

of physical illnesses. Studies have shown that general inpatient medical care can be cut by as much as 70% following mental health treatment, and outpatient utilization may be lowered by as much as 20%. Several studies have conclusively demonstrated the cost-savings associated with psychological interventions: In a study of the Federal Employee Health Benefits Plan, patients with chronic medical diseases who received psychotherapy services consumed 56% fewer medical services than those patients who did not receive psychotherapy. Medicaid patients hospitalized for physical ailments and provided mental health interventions realized average cumulative savings of \$1,500 over a 2 and 1/2 year period, and the cost of the mental health intervention was entirely paid for by the decrease in medical services utilization. And a three year study of over 10,000 Aetna beneficiaries showed that after initiation of mental health treatment, beneficiary medical costs dropped continuously over a 36-month period; the health costs of one mental health treatment group fell from \$242 the year prior to the treatment to \$162 two years after treatment, and other subject groups experienced similar dramatic decreases.

As we have mentioned earlier, mental illness damages our nation's productivity and hurts our economy, but fortunately, we know that mental health treatment restores productivity in the workplace. For instance, one study determined that prior to inpatient substance abuse treatment, 42% of the individuals in the study reported absences due to drugs and 39% reported tardiness. One full year after treatment, these numbers had dropped to 5% and 7% respectively. The McDonnell Douglas Corporation, by implementing an employee assistance program, reduced employee terminations of those individuals participating in substance abuse programs by 42% and for those participating in the mental health programs by 28% over a four year period when compared to those employees in the traditional health program. Over a five year period, the employee assistance program reduced absenteeism by 29% and 25% for those in substance abuse treatment and mental illness treatment programs respectively.

Outpatient mental health services hold the promise for the delivery high quality and cost-effective services in the reformed health care system.

Outpatient mental health services, particularly outpatient psychotherapy, are generally as effective as inpatient treatment and may be delivered for a fraction of the cost. The ability of the reformed health care delivery system under President Clinton's plan to contain mental health and substance abuse costs while providing our people with high quality mental health care will be greatly enhanced if the use of outpatient psychotherapy and other outpatient services is encouraged through the incentives contained in the comprehensive benefits package.

Facing skyrocketing mental health costs, many businesses across the United States have already moved to a mental health benefits structure which encourages the use of outpatient benefits. Their results have been dramatic. In 1989, BellSouth Corporation adopted a mental health benefit that encouraged employees to receive care in the least restrictive setting. Within three years after implementation of the new benefit structure, BellSouth's total mental health bill decreased by \$6 million, and the portion of their total health costs attributable to mental health fell from 17% to 9.2%. In one year Chevron saw a 21% decrease in psychiatric hospital admission costs due to the implementation of a provider network that encouraged outpatient mental health care and intermediary services. First National Bank of Chicago saved 30% in mental health and substance abuse costs over four years as a result of a redesigned mental health benefit that expanded their range of services covered and reimbursed outpatient care at 85%.

Many businesses like BellSouth, Chevron, and the First National Bank of Chicago have discovered that high quality, cost-effective mental health care can be delivered through outpatient care. Fortunately, the Administration has noticed the successes of these businesses and is implementing a flexible mental health benefit in the comprehensive benefits package which will allow relatively inexpensive outpatient psychotherapy services to be "substituted" for inpatient services in appropriate circumstances.

The mental health benefit in the comprehensive benefits package of the President's plan must be further refined to encourage the use of outpatient psychotherapy services.

The "substitution" of mental health benefits towards inexpensive outpatient psychotherapy services will ensure that enrollees under the new health care system receive appropriate, high quality, and cost-effective mental health care. Under the present health care system, insurance companies typically limit mental health benefits to reduce their reimbursements. These limits commonly lead to cost-shifting to families and individuals to pay for the balance of the treatment or termination of treatment prior to successful outcome. Insurance expenditures might be saved, but undoubtedly, costs to the overall system rise as repeated and more expensive care is consumed to treat individuals who have reached their outpatient annual limits.

By allowing the substitution of outpatient for inpatient benefits, the Administration has avoided the danger of relying too heavily on inpatient treatments, which we believe would have driven up expenditures and ultimately led to further limitations on the aggregate benefit to the detriment of all persons needing mental health services. Essentially, the substitution will allow outpatient psychotherapy benefits to be provided through an equivalency multiple to the hospital inpatient day limit. In appropriate circumstances, therefore, additional outpatient psychotherapy visits will be available to needy patients through direct substitution of inpatient benefits.

Outpatient psychotherapy offers relatively inexpensive and effective care for the entire spectrum of mentally ill individuals, including seriously mentally ill persons. Through substitution, President Clinton's plan allows for treatment for significant patient populations through more appropriate outpatient services. All evidence indicates that recent increases in mental health care costs have occurred only in inpatient alcohol and drug and inpatient adolescent care treatment settings. Research now concludes that nearly 50% of these patients could be treated as effectively or more effectively in outpatient settings. As Senator Paul Wellstone has pointed out in a very recent article, "We can treat ten people once a week for a year of outpatient therapy for what it costs to keep one person in the hospital for 30 days."

The outpatient psychotherapy benefit. Psychologists and many other mental health providers are extremely concerned with the inadequacy of the outpatient psychotherapy benefit outlined in President Clinton's plan. Unless amended to make intensive psychotherapy more accessible, the 30 visit outpatient psychotherapy benefit at 50% copayment in relation to the generous inpatient benefit will do no more than codify the current inefficiency and inequity in the mental health delivery system, denying humane care to millions of mentally ill persons and promising to waste billions of dollars in the system.

For many mentally ill persons suffering from a wide range of mental illnesses, including those with persistent mental disorders and children, who often are best served through least-restrictive outpatient psychotherapy, 30 outpatient visits will not offer effective treatment. Research

demonstrates that persons with severe mental illness show improvement after 26 sessions. Through substitution, President Clinton's plan promises that these individuals will receive the amount of additional psychotherapy that they need and that they will not be locked out of effective treatment by an arbitrary 30 visit limit.

Actuarial substitution for additional psychotherapy. The President has taken a major step toward ensuring that mentally ill persons receive adequate and appropriate levels of psychotherapy by allowing an actuarial substitution of the inpatient hospital mental health benefit to access additional psychotherapy visits. We know that the cost associated with permitting additional psychotherapy is minimal; for instance, the removal of a 30 visit limit to an outpatient psychotherapy benefit to one without arbitrary limits increases total mental health and substance abuse costs by a mere 3.2%. This minimal increase in mental health costs would offer invaluable and appropriate treatment for seriously mentally ill persons who would otherwise be improperly funneled into inpatient settings. At the same time, the mental health delivery system would be more effective in containing costs through the reduced use of inpatient hospitalization.

Unfortunately, under the Administration's plan mentally ill persons may never be permitted to access the additional psychotherapy that they need. The proposal authorizes to the health plan discretion to determine the patient's need for additional psychotherapy through the actuarial substitution. Additionally, the substitution is only available "to prevent hospitalization or to facilitate earlier hospital release." Considering the long and unfortunate track record of the extreme limits that managed care has placed on psychotherapy services, we believe that health plans in the new system will ignore patient need and refuse additional psychotherapy sessions.

President Clinton's "managed competition" plan relies heavily on managed care. Managed care entities, and more recently, other third-party payers, have redefined traditional outpatient care to make it as brief as possible. These entities have so often egregiously limited care, reimbursing only a fraction of the available benefit, that those mentally ill persons in greatest need of care essentially receive no care.

In addition to the potential denial of the use of the entire 30 visit psychotherapy benefit, we can easily envision a system where health plans uniformly deny the additional, substituted outpatient psychotherapy benefit for enrollees, even in instances where these persons desperately need to continue their treatment. Therefore, actuarial substitution must be mandated, determined by a health professional, and not left to the discretion of the health plan. In addition, eligibility for additional visits must be based on a determination that psychotherapy is medically or psychologically necessary, or that it is the most appropriate form of treatment and that inpatient and intensive nonresidential treatment would be ineffective or inappropriate, as is often the case.

The 50% copayment for outpatient psychotherapy. Like the 30 visit psychotherapy limit, the 50% copayment will provide incentives to use expensive and often inappropriate inpatient treatment into the reformed system. If this occurs, this incentive will reproduce the short-sighted and irrational present structure, where the insurance and hospital industries are promoted and adequate outpatient care is ignored.

In 1984, the Medicare PPS/DRG system was established so as not to apply to psychiatric units or hospitals. As a result, entrepreneurial dollars were directed into psychiatric facilities, and the number of psychiatric facilities doubled between 1984 and 1988. The result has been, in some cases, disaster, because the explosion of facilities led to "provider demand" for patients, allowing

some inpatient providers to abuse the system.

Consider the case of National Medical Enterprises (NME), one of the largest psychiatric/rehabilitation hospital chains in the country. Federal and several State authorities are currently investigating NME on charges that several of its facilities paid "bounty hunters" to snare patients and hold them against their will in order to receive their insurance reimbursement. NME awarded bonus payments to psychiatric hospital managers for high occupancy rates. Hundreds of patients are now suing NME, relating how they were cruelly treated then miraculously released as "treated" when their insurance coverage ran out.

The 50% copayment for outpatient psychotherapy is relatively high when compared to the inpatient mental health cost-share. As in the present system, the President's plan will pose for the families of mentally ill persons the burdensome alternative of keeping the family member at home with no outpatient treatment, because the cost-sharing is too expensive for them to afford, or using hospital-based services, giving themselves respite and eliminating their financial burden. It is this dual dynamic which has driven costs in the present mental health system. Unfortunately, President Clinton's plan seeks to implement this inefficiency into the reformed mental health delivery system.

People in the reformed system should be encouraged to utilize outpatient psychotherapy without arbitrary limits at copayment rates that are similar to inpatient cost-share. At a minimum, people needing outpatient psychotherapy should be permitted to pay for services on a sliding scale according to their income and to apply their co-payments to the aggregate out-of-pocket limit provided to protect families in the comprehensive benefits package from inequitable and unconscionable financial burden. Reducing the copayment burden on families will produce some cost to the total mental health and substance abuse system but has the greater potential to prevent gross overspending in the much more expensive inpatient system.

In conclusion, we would emphasize our strong belief that the President's mental health benefit, with its emphasis on expensive inpatient mental health care, will burden the reformed system with the warped incentives that have limited patient access to care and spiraled systemic mental health costs. The outpatient psychotherapy benefit is so comparatively limited and the inpatient benefit is so rich, that we believe that mental health outlays will skyrocket, which could eventually lead to a tragic scaling back of mental health benefits and access of the mentally ill to adequate treatment.

The actuarial substitution of inpatient benefits for outpatient psychotherapy offers a step towards a more cost-efficient and appropriate system of mental health care, but the plan must be redesigned to ensure that benefit substitution is accessible and available at cost-share rates which are fair and encourage the use of the psychotherapy benefit.

Consumer protections must be implemented to prevent managed care abuses.

We have already indicated our concern that health care plans in the "managed competition" system, through managed care techniques, will work to impinge on appropriate patient care. Because the actual delivery of all services, particularly mental health services, in the comprehensive benefits package will depend heavily on determinations made by managed care entities and through managed care techniques, we find particularly disturbing the fact that the

Health Security Act contains no specific guidelines to protect the system from the abuses of unbridled managed care.

The managed care financial incentive structure is designed to contain costs by rationing mental health care, instead of addressing the specific needs of the patient. When the provider of care stands in a financial conflict of interest with the recipient of care, the availability of care is jeopardized. Providers are rewarded for limiting care, and patients who are promised a 30 patient limit will likely receive a fraction of their benefit. It is this financial conflict of interest of the provider which jeopardizes patient care.

Scrutiny of managed care should be heightened due to a Government Accounting Office (GAO) study released in October which has concluded that there exists no conclusive evidence that managed care health plans save money. The study noted that managed care plans saved money by enrolling younger and healthier persons not by efficiently managing patient care, and that in one study, HMO premiums averaged only 2-4% less than other plan premiums in 1992. This finding directly challenges the President's plan premises that moving beneficiaries into managed care structures will contain costs.

Since managed care will be a foundation of the reformed health care system under the Clinton plan, strong quality standards to protect the patient and to reduce rationing of care must be implemented into the statutory language. We suggest that the National Health Board might be empowered to develop and enforce managed care and utilization review standards, but whatever the vehicle, at a minimum plans should be required to:

- ♦ separate clinical review from financial interests;
- ♦ adhere to quality standards which protect the patient;
- ♦ use reviewers who are licensed or certified in the areas of mental health care under review;
- ♦ make public the review standards and criteria used in evaluating health care plans;
- ♦ establish arbitration to resolve appeals;
- ♦ ensure that patient confidentiality is protected;
- ♦ implement a review and appeal system which reviews decisions quickly; and,
- ♦ maximize patient choice of services and mental health providers.

The President's plan contains scattered references to some of these protections including: protection of the privacy of patient data, implementation of a National Quality Management Program to develop a quality information and accountability program to be applied to health plans, and a vague provision which may mandate that managed care entities publish their protocols for determining care and containing costs. However, the plan does not contain specific and strong patient protections against potential managed care abuses. We strongly believe that these patient protections will ensure that patients are protected and that managed care companies effectively operate to manage care rather than ration care.

Nonphysician provider services must be encouraged in the reformed system.

Psychologists and many other nonphysician mental health providers are concerned that the Clinton plan may fail in its stated purpose of ensuring that patients have an effective choice of providers. The Health Security Act must ensure that qualified nonphysician providers are able and encouraged to render their services in all settings where appropriate, and in so doing, the plan will meet its goal of providing access for patients to all qualified health professional services.

Inappropriate restrictions on nonphysician providers. Although the President's plan does much to eliminate the inappropriate and noncompetitive strangle hold that physicians have on the health care system through archaic and restrictive statutory and regulatory language, many provisions may continue the tradition of inappropriately prohibiting psychologists and other nonphysician mental health providers from rendering care to their patients. Areas of particular concern are:

- ◆ The plan defines health providers and nonphysician health providers in terms of their ability to render "physician" services. This definition is archaic and incompatible with the purpose and goals of the health plan. Instead, health professionals and the services that they provide should be defined according to their individual skills and training. In addition, States, health alliances, and health plans should ensure that enrollees in the system have access to a sufficient range and mix of providers and specialty providers.
- ◆ The plan must define hospital and other inpatient settings so that patients do not lose access to nonphysician provider services and must eliminate restrictions in current law that pose barriers or prohibit nonphysicians from practicing in accordance with State law. Of particular concern to psychologists is the indication that the President's plan will apply the Medicare "hospital" and "psychiatric hospital" definitions to the entire system. Since the Medicare hospital and psychiatric hospital conditions of participation provisions improperly require physician supervision of patient care, psychologists in several states will lose their present ability to independently supervise and render care for their patients in these settings. Therefore, to ensure access of all patients to qualified psychologists services, the plan must drop the Medicare hospital and psychiatric hospital definitions and ensure that psychologists and other nonphysician providers are able to care for their patients according to their training and competence. Additionally, the plan should eliminate arbitrary barriers to hospital membership and appropriate clinical privileges.
- ◆ Several provisions in the plan, such as the provisions relating to antitrust enforcement and "safe harbors" in the new system, inappropriately apply only to physicians. These must be reexamined, and psychologists and other nonphysician providers must be included where appropriate.
- ◆ The plan must eliminate all discriminatory and anticompetitive practices against nonphysicians. Specifically, the plan must include language which prohibits health plans from discriminating against any class of health professional. In this way, enrollees are able to access the full range of available providers in their area, and the Health Security Act will accomplish its stated goal that "individuals in the United States should be afforded a meaningful opportunity to choose among a range of health plans, health care providers, and treatments." Relatedly, the plan must ensure an appropriate and sufficient

mix and representation of all health professionals on the national, regional, and State health boards and health plans.

Psychologists' services in rural and underserved areas. Of particular concern for psychology is the impact of nonphysician restrictions in rural areas. Two-thirds or more of all U.S. counties do not contain a single psychiatric physician, while psychologists are more widely dispersed and available to render mental health services.

President Clinton's plan has proposed to expand mental health services access in rural areas through investment in inpatient and non-residential infrastructure. While infrastructure investment is important in some cases, the system must include incentives for enrollees to use the least costly, most accessible forms of community-based and health professional services in underserved areas. Effective outpatient services rendered by psychologists and other nonphysician mental health professionals are currently available in rural and underserved areas.

The plan must encourage psychologists and other mental health providers to offer their services in rural areas. The plan offers educational and financial incentives, such as a non-refundable personal tax credit and a deduction of up to \$5,000 in annual student loan interest, for primary care and certain other professionals to render services in rural areas. Given psychology's excellent track record in delivering mental and behavioral health care in rural areas, these provisions should be expanded to include psychologists.

Psychological and neuropsychological services. Within the specifications of the comprehensive benefits package, the APA voices concern that psychologists may not be permitted to offer their services for certain populations for whom they now typically render care:

- ♦ The mental health benefits in the comprehensive benefits package must include the full range of psychological and neuropsychological services, including diagnostic and assessment services. These services are widely consumed in the United States, and psychologists, possessing the most diverse and comprehensive armament of screening and assessment tools in the mental health arena, are typically relied upon to provide these services.
- ♦ Psychological and neuropsychological services are typically used in the rehabilitative process to assess, remediate, and restore the cognitive functioning of patients who are impaired as a result of a variety of physical illnesses and injuries. The comprehensive benefits package should be amended to include psychological and neuropsychological services as part of the outpatient rehabilitation benefit.

The APA specifically requests that Congress protect the participation of nonphysician providers, including not-only psychologists but social workers, nurses, optometrists, podiatrists, chiropractors and other groups who have a pro-competitive impact on health care costs and provide very cost-effective alternative treatments. We hope that Congress will be very careful in its review of the language of the Administration's plan to make sure that vaguely articulated provisions in the legislative draft are clarified to provide for the full range of nonphysician services.

Conclusion.

In our testimony, we have emphasized those areas directly related to the delivery of psychological and mental health services. However, we have significant questions about a number of the more general features of the plan, particularly the formation and operation of accountable health plans, the development and authority of the National and Regional Health Boards, and the development of systems to evaluate quality of care and provider performance. While this forum does not permit a thorough discussion of these issues, we will seek further opportunities to discuss these issues with you, Chairman Waxman and Members of the subcommittee as you continue to examine the President's proposed legislation.

The APA commends the President and Mrs. Clinton for their enormous contribution in advancing health care reform, and in particular, their unwavering leadership in developing mental health policy that addresses the long-neglected plight of those with mental disorders. APA stands committed to the goals that the President has set and looks forward to working with Congress to shape and improve the Administration's plan.



AMERICAN
PSYCHOLOGICAL
ASSOCIATION

Principles for Mental Health and Psychological Services in Health Care Reform

Preamble

All American citizens and residents, regardless of race, national origin, income, religion, age, sex, sexual orientation, language, or geographic residence, have the right to health care and must be covered under any national health care plan.

To ensure participation of all citizens and residents, the national health care system shall: not discriminate against any individual on the basis of current health status, including any coverage exclusion or limitation based on a pre-existing condition; base the cost of coverage on the concept of broadly shared risk to be determined by community-wide rating; and ensure that health care coverage is portable and continuous.

Fundamental reform of the health care system includes:

- Access to health care for all;
- Appropriate and fair cost containment;
- Improved quality of care;
- Comprehensive health benefits, including mental health benefits for all people experiencing mental disorders and psychological services for the diagnosis, prevention, and treatment of certain medical disorders; and
- Improvement in the organization and delivery of care.

The Mental Health Benefit

People who need mental health care, regardless of age or the severity of their illness, should have access to a comprehensive array of mental health and psychological services, which emphasize treatment in the least restrictive, and culturally sensitive and age appropriate setting. Psychologists are uniquely qualified to furnish many needed services and provide a full range of preventive, acute, specialized, rehabilitative, and chronic care services.

Mental health services in a continuum of care include:

- ✓ **PREVENTIVE SERVICES**, including developmental and mental health screening and assessment and early intervention to avoid or ameliorate illness
- ✓ **EMERGENCY SERVICES**, including crisis intervention
- ✓ **OUTPATIENT AND AMBULATORY SERVICES**
 - ↳ short-term psychotherapy
 - ↳ intensive psychotherapy, particularly for people suffering serious and debilitating behavioral disorders
 - ↳ case management services
 - ↳ medication consultation
 - ↳ hospital alternatives such as day treatment and psycho-rehabilitation services
 - ↳ psychological rehabilitative services and neuropsychological services for those with mental

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and behavioral disorders. (For medical or neuropsychological disorders, rehabilitation and neuropsychological services should be appropriately covered as a medical or diagnostic benefit.)

- ✓ **DIAGNOSTIC TESTING AND ASSESSMENT**
- ✓ **INPATIENT AND RESIDENTIAL TREATMENT**
- ✓ **PRESCRIPTION DRUGS**
- ✓ **ADDITIONAL AND SPECIAL SERVICES FOR CHILDREN AND ADOLESCENTS**, including comprehensive and regular screening of their mental and physical health and developmental factors and school-based services
- ✓ **ADDITIONAL AND SPECIAL SERVICES FOR WOMEN**, including treatment for psychological and emotional disorders resulting from sexual or physical abuse and violence
- ✓ **ADDITIONAL AND SPECIAL SERVICES FOR PERSONS WITH HIV/AIDS**

In the absence of a comprehensive Federally-mandated mental health benefit, Federal national health reform legislation should not pre-empt state initiatives to ensure the provision of benefits for persons needing mental health treatment.

Reform of the Mental Health Delivery System

Equity

The provision of mental health services should not be limited by artificial or arbitrary numbers of visits, days, or financial caps. Duration and scope of services should be based on medical or psychological necessity in accordance with professional standards of reasonable care. Individuals requiring mental health treatment and their families should not need to spend a disproportionate share of their income and resources to obtain services.

Efficiency

Appropriate, high quality mental health care should be delivered in the most cost-effective manner. The present mental health delivery system wastes resources, leaving those most in need without adequate care. Resources need to be more appropriately allocated to encourage the use of cost-effective forms of treatment and to ensure access to a broad array of integrated outpatient and inpatient mental health services for all who require care. A reformed mental health system under any national health plan must incorporate the following tenets:

- ◇ People with serious mental illness should be treated through a more properly designed mental health benefit, which incorporates adequately funded long-term care services.
- ◇ Outpatient mental health treatment, compared with inpatient treatment, is relatively cost-effective and as efficacious in many treatment areas, and studies have demonstrated that the use of copayments sufficiently controls the demand for utilization of outpatient mental health services without the need to resort to arbitrary limits. Copayments should be scaled to income or subsidized in a manner to avoid undue financial hardship on individuals seeking treatment.
- ◇ For inpatient treatment, copayments and other cost-sharing will ensure greater individual responsibility for treatment cost. Appropriate case management with preadmission review by a financially disinterested entity or professional will help reduce unnecessary inpatient costs.

Quality

To eliminate the serious quality of care problems that managed care programs have created for patients needing mental health services, service delivery entities should be required to adhere to standards which protect the patient, including:

- ❑ separating clinical review from financial interest
- ❑ ensuring the provision of an adequate range of high quality, individualized services
- ❑ maintaining liability for negligent cost-containment mechanisms and review determinations
- ❑ ensuring confidentiality of Patient-Provider information
- ❑ maximizing patient choice
- ❑ making public the review standards and criteria used in evaluating care plans
- ❑ using reviewers who are licensed or certified in the areas of mental health care under review
- ❑ limiting review frequency and amount of information requested
- ❑ ensuring that decisions are quickly made
- ❑ establishing arbitration or similar hearing arrangements to resolve appeals.

A national plan must include these minimum standards for managed care. Federal legislation should not pre-empt existing state statutes which protect patients from current managed care abuses.

Access to Psychological Services

Health and behavioral services are cost-effective and efficacious. Consumer participation should be encouraged in treatment planning decisions, including the selection of services, settings, and providers. State provider freedom of choice laws should be protected and expanded to apply to managed care entities.

To meet the needs of all Americans, particularly those in rural and underserved areas, national health care reform should promote the training of psychologists and other mental health providers. Linkages between psychologists and primary care providers should be encouraged.

The reformed mental health care system should promote the public mental health system's role of providing services for those individuals who might not otherwise receive mental health care. States should be encouraged to provide an array of mental health and rehabilitation services, and general health, mental health, and social services should be integrated, particularly for the severely mentally ill. Public systems should be afforded the opportunity and be encouraged to compete with private plans formed under the national system to offer specialized or comprehensive mental health and rehabilitative services.

Research

National health reform should be committed to comprehensive mental health research with increased behavioral science, health psychology and psychological treatments studies. Mental health research serves as a foundation for ongoing improvement in the detection, treatment and prevention of psychological disorders and in the definition of the psychological and neuropsychological components of conditions with physical etiology.

Many of the leading health problems which most seriously impact our nation's workforce, including alcohol abuse, drug abuse, depression, stress, mental health problems and cigarette smoking, have a psychological or behavioral component. Psychology and particularly health psychology initiatives should be integrated into mainstream health and medicine as key treatments and interventions to combat these crippling and costly problems.

Testimony of

James K. Walsh, PhD
 Chairman
 Committee on Government Affairs and Public Policy
 of the
 American Sleep Disorders Association

Mr. Chairman and members of the subcommittee, thank you for the opportunity to present the views of the American Sleep Disorders Association on health care reform.

The ASDA is an organization of 2500 clinicians and researchers that is here to speak on behalf of the millions of Americans who suffer from a chronic sleep disorder.

The National Commission on Sleep Disorders Research, which issued its report to Congress earlier this year, found that at least 40 million persons in the United States suffer from a variety of serious, sometimes life-threatening sleep-related problems.

Among the most common sleep disorders are:

- 1) **Sleep apnea**, which affects 10 million Americans, causes an individual to stop breathing frequently during sleep--sometimes as many as a hundred times a night. The resulting loss of oxygen and cardiopulmonary distress can lead to heart attacks, high blood pressure, and death from cardiopulmonary complications. Some of the most devastating effects of sleep apnea are compounded during the day when persons suffering from the disorder attempt to function in society when they are physically and mentally impaired by a lifetime of insufficient sleep, leading to errors in judgment at the work site, carnage on the highways, or falling asleep at work or during a conversation.
- 2) **Narcolepsy** is a disorder in which an individual lives in a constant state of sleepiness, no matter how much sleep may have been obtained the night before. Persons with narcolepsy are prone to falling asleep at inappropriate times and susceptible to poor performance at school and at the workplace. Many people suffering from this disorder have attacks of cataplexy in which all of their muscle tone is lost, causing paralysis. Over 250,000 Americans are afflicted by this neurological disorder for which there is no effective treatment.
- 3) **Persistent insomnia** affects 30 million American adults each year, and can be caused by many different medical, psychiatric, and behavior disorders. Commonly, the quality of life is markedly affected, and occasionally tragic results occur.
- 4) **Sudden Infant Death Syndrome** claims the lives of approximately 7000 otherwise healthy infants each year and is a devastating disorder about which very little is known.

These are just four of the more than seventy sleep disorders reported by the National Commission.

The American Sleep Disorders Association embraces the principles of health care reform outlined in the Clinton proposal. For too long, too many citizens of this nation have not had access to health insurance or to the abundant technology and medical advances that make our medical capabilities the best in the world.

Many individuals who suffer from untreated sleep disorders find themselves displaced in their careers because of their inability to function in today's fast moving society. Because of their employment challenges and therefore lack of access to the health care system, many go untreated. In fact, through a combination of their inadequate resources and a lack of sufficient training to recognize sleep disorders among the medical profession, the average person with a sleep disorder goes seven years before they are even diagnosed, much less adequately treated.

It is hoped that the work of the National Commission on Sleep Disorders Research will help to reverse this pervasive ignorance about sleep disorders and encourage public policies, medical training, and public awareness that will provide those with sleep disorders adequate medical care for their conditions.

Mr. Chairman, beyond our support for the basic principles of health care reform, there are several specific items within the proposal about which we are concerned that we would like to bring to your attention:

1) Medicare cuts: Under the physician fee schedule, Medicare reimbursement for polysomnography, the primary diagnostic test used to diagnose a sleep disorder, is only about one-third (1/3) of the cost of performing the test. That's cost, not price. Given the increase in sleep disorders among the elderly, as well as other medical conditions, further cuts in the Medicare program threaten to make our nation's senior citizens second-class citizens. Our organization would argue that a system that is already overtaxed should not be the target of further cuts. The ASDA has been in unsuccessful negotiations with HCFA for 18 months around the low valuation of polysomnography. HCFA has not addressed the valuation problems of polysomnography and RBRVS. The nation's seniors may be under-RVUed out of sleep medicine care.

2) Health care workforce and training: Despite the acknowledged need for more primary care physicians and other health professionals, those in the sleep disorders field would express dire concern about a system that is geared toward establishing disincentives for talented health professionals to pursue specialty training. Because the field of sleep medicine is a relatively new one, we believe such disincentives would severely limit the development of a core group of specialists to treat the millions of Americans with undiagnosed sleep disorders. The result of a lack of access to diagnosis and treatment of sleep disorders is continued persistent medical problems for those persons whose suffering could be identified and successfully treated.

3) Health Alliances, PPOs, and HMOs: An underlying concern of patients suffering from sleep disorders and the physicians who treat them is the expected squeeze on benefits for those procedures not specifically identified in the basic benefits package. For example, at the Health Net capitated system at Scripps Clinic, the percentage of outpatient dollars allotted for all of sleep medicine is 0.3%. However, current epidemiological data suggest a requirement 10 times higher.

Because of the lack of awareness about sleep disorders among the public and health care professionals, it is very easy to imagine a health insurer arbitrarily eliminating coverage for diagnosis and treatment of sleep disorders. Furthermore, it is just as easy to imagine that a managed care system, a preferred provider organization, or a health maintenance organization would place a very low priority on securing the services of a qualified sleep specialist. In any prepaid, capitated system, adequate allotment of funds for sleep medicine must be assured by Congress.

Mr. Chairman, Congress, in fact, this subcommittee recognized the importance of sleep disorders in America when it established the National Commission on Sleep Disorders Research which identified the pervasive national problems in health, occupation and transportation safety, and general well being associated with sleep disorders. Notwithstanding the laudable principles of the health reform proposal, some of the detailed recommendations appear to insure the opposite effect. Public policy leaders who have awakened the world to the importance of sleep disorders must not allow our nation's health policies to slip back into the darkness of ignorance about something we spend one-third (1/3) of our lives doing.

We hope that you will carefully consider our testimony when deliberating health reform legislation.

AMERICAN THERAPEUTIC RECREATION ASSOCIATION

STATEMENT (Re: H.R.-3600)

Mr. Chairman,

My name is John Zorack, Counsel for the American Therapeutic Recreation Association, and we appreciate your invitation to offer this statement for the record.

The American Therapeutic Recreation Association, the largest national organization representing recreational therapy professionals, has prepared this statement to facilitate the understanding of the critical role recreational therapists play in comprehensive rehabilitation to express its support for the principles delineated in the national healthcare reform effort and to facilitate the recognition of the cost-effective nature and congruity of utilizing recreational therapy services to ensure the total rehabilitation and quality of life of persons with disabilities as an aspect of the national healthcare reform endeavor.

Recreational therapy, also referred to as therapeutic recreation, is defined by the United States Department of Labor as a profession of specialists who utilize activities as a form of treatment for persons who are physically, mentally or emotionally disabled (Paraphrased, Occupational Outlook Handbook, U.S. Department of Labor, Bureau of Labor Statistics, April 1991). Differing from diversional or recreation services, recreational therapy utilizes various activities as a form of "active treatment" to promote the independent physical, cognitive, emotional, and social functioning and quality of life of persons disabled as a result of trauma or disease, by enhancing current skills and facilitating the establishment of new skills for daily living and community functioning.

Recreational therapy services are delivered by qualified professionals with training and education in therapeutic recreation/recreational therapy service delivery and professionally certified by the National Council for Therapeutic Recreation Certification (NCTRC).

The professional certification designation is Certified Therapeutic Recreation Specialist (CTRS). The credential requires a bachelor's degree or higher from an accredited institution of higher education in the area of therapeutic recreation (recreational therapy), an approved internship under the supervision of a professionally credentialed CTRS, and the passing of a national certification examination administered for NCTRC by the Educational Testing Service (ETS). NCTRC is an approved credentialing body recognized

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by the National Organization for Competency Assurance (NOCA).

According to the United States Department of Labor's 1992 Occupational Outlook Handbook, "Employment of recreational therapists is expected to grow faster than the average for all occupations through the year 2005, because of the anticipated expansion in long-term care, physical and psychiatric rehabilitation, and services for the disabled." There are approximately 32,000 employment positions in the United States and the growth rate is projected at 39% through the year 2005. It is important to note that employment is available in a wide variety of settings, working with individuals with varying types of disabilities and illnesses.

Recreational therapy services are delivered in a variety of settings depending on the needs of the consumer. Settings in which services are traditionally delivered include freestanding rehabilitation hospitals, rehabilitation units in general hospitals, long-term care or skilled nursing facilities, comprehensive outpatient rehabilitation facilities, inpatient and outpatient mental health/psychiatric facilities, substance abuse rehabilitation facilities, home healthcare services, and residential facilities for persons with disabilities. In addition, recreational therapists are employed within community recreation and park agencies to address the recreation and leisure needs of individuals with disabilities.

Research indicates that recreational therapy services, provided by qualified professionals, offer a diversity of rehabilitation benefits addressing the needs of individuals with a range of disabling conditions. A recent conference sponsored by Temple University and funded through the National Institute on Disability and Rehabilitation Research (NIDRR), evaluated the efficacy of therapeutic recreation services as a treatment modality on rehabilitation outcomes. Research has demonstrated the values of recreational therapy services for individuals with a range of diagnoses.

Recreation therapy is a component of comprehensive rehabilitation. Such comprehensive rehabilitation services have proven to be cost-effective. A survey conducted by the Health Insurance Association of America indicated a savings of \$11 for every \$1 spent on rehabilitation. In addition, other studies have indicated that quality comprehensive rehabilitation services reduce long-term hospitalization and nursing home stays for stroke patients and thus save the American economy \$17,000 per year per patient. Recreational therapy services play a significant role in the comprehensive rehabilitation effort.

- Recreational therapy services are an effective means for

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improving the functioning, independence, and quality of life of persons with illness or disability. The provision of recreational therapy services, in concert with related disciplines such as occupational therapy, physical therapy, and speech therapy, offer the client or patient comprehensive rehabilitation services. The availability of the proper mix of services and the therapist-client relationship proves to be of maximum benefit to the consumer.

- Expenditures in comprehensive rehabilitation services are an investment in human potential and are cost-effective. Recreational therapy services utilize both individual and small group intervention strategies, therefore, staff/patient ratios are cost-effective. More patient treatment hours per therapist can be generated through the use of such small group interventions. Furthermore, recreational therapy services for older Americans are equally cost-effective. Recreational therapists play a significant role in assisting older adults to maintain current skills and re-establish previous levels of functioning in the least restrictive environment possible including the in-patient, out-patient, and day service settings. Recreational therapists work in concert with and provide complement to other treatment modalities.
- Recreational therapy plays a primary role in enhancing the quality of life and productivity of the consumer. Enjoyable activities and social relations are significant in promoting the quality of life and productivity of the individual with a disability. Recreational therapists offer individuals with disabilities the opportunity to resume normal life activities and to establish/re-establish skills for successful social integration. In addition, the therapist will employ activity treatment modalities which promote physical skill development, enhance feelings of well-being, foster successful experiences, facilitate continued involvement in the rehabilitation process, and establish new life activities for continued growth.

Recreational therapy is listed as one of the physical rehabilitation services in the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards. Recreational therapists are standard treatment team members in psychiatric rehabilitation, substance abuse treatment, and physical rehabilitation services in both in-patient and out-patient settings. In addition, recreational therapists are designated as members of the comprehensive core treatment team in the acute brain injury, the post-acute brain injury, and the inpatient

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rehabilitation standards of the Commission on Accreditation of Rehabilitation Facilities (CARF).

Since the 1940's recreational therapists have served as active members of the interdisciplinary treatment team addressing the psychosocial and physical rehabilitation needs of the consumer. Recreational therapy will certainly have an active role in a managed care and managed competition system with emphasis on providing opportunities for meeting rehabilitation goals, accessing life skills and opportunities, and providing quality services in the most cost-efficient manner. These functions must be performed on an on-going basis in concert with other allied health fields such as physical therapy, occupational therapy, and speech therapy and audiology. Although some overlap occurs between all disciplines in areas such as activities of daily living, vocational and avocational adjustment, and application of motor performance skills in the natural environment, the disciplines mutually complement each other in the rehabilitation environment. For instance, each discipline may work on the development of physical skills and activities of daily living. Much of the responsibility for community integration efforts in the rehabilitation setting, however, has become the charge of the recreational therapist. In addition, recreational therapists assist the consumer in developing or redeveloping social skills, discretionary time skills, decision making skills, coping abilities, self-advocacy, discharge planning for re-integration, and skills to enhance general quality of life. As with each allied health discipline, the rehabilitation goals are based upon individual needs. The ability to meet the physical and psychosocial needs of the person affected by a disability is critical to the pursuit of independent productivity in vocational and avocational endeavors. As our healthcare system increases efforts to provide quality treatment services through out-patient formats, the role of recreational therapy, in community adjustment for all persons with illness and disability will continue to be more readily realized.

The American Therapeutic Recreation Association is in support of a healthcare package which ensures coverage for all Americans. This healthcare package should include cooperative efforts between public and private health insurance programs. The healthcare reform package should also include standard coverage of a range of rehabilitative services including recreational therapy services. Current practices restrict the range of rehabilitation services that are identified as standard reimbursable services under Part A of the Medicare and Medicaid Guidelines (e.g. physical therapy, occupational therapy, speech therapy and respiratory care). Through inclusion of recreational therapy services under the proposed healthcare initiative the healthcare provider will have access to additional options to meet the treatment needs of the consumer. The availability of a broader base of outcome oriented

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therapies and the application of a proper combination of therapeutic modalities will offer several dramatic benefits.

- The specific needs of the consumer can be better met with the greater availability of disciplines.
- Proper mixes of therapies in a managed care and managed competition system offers a more cost-effective means to meet consumer needs in both in-patient and out-patient service settings.
- This approach responds in the most effective and efficient manner to the critical shortage of healthcare practitioners by expanding the pool of available allied health professionals.
- The inclusion of such services will positively impact on the quality of life of the individual and will serve a significant role in the prevention of incapacitating secondary disabilities.

The inclusion of recreational therapy offers an opportunity for accessing these treatment options to meet the "personal assistance services" of the healthcare consumer. This approach would provide expanded options and service mixes which will prove more cost-effective. For instance: At the current time, if an individual is receiving rehabilitation services for a cerebral vascular accident (stroke), the individual will likely be involved in 1:1 (one on one) physical therapy services to improve range of motion. Should there be an option of inclusion of recreational therapy services (frequently prescribed in group format) the person could receive 60% physical therapy 1:1 services and 40% recreational therapy services in aquatic therapy groups. Within the psychiatric rehabilitation setting, recreational therapy services, in concert with other disciplines such as occupational therapy, can more effectively address the social and community adjustment skills of persons with mental illness or substance abuse histories. Furthermore, the application of a mix of effective interventions (e.g. occupational therapy, physical therapy, recreational therapy, speech pathology services) in the out-patient setting will prove to be the most effective and economical approach to the delivery of quality treatment services to the American people. It is only through the application of an efficient cost-effective mix of services, designed to be in the best interest of the consumer, that quality, outcome oriented treatment can be maximized and the quality of life of the consumer enhanced.

In conclusion, the American Therapeutic Recreation Association is in support of cost-effective healthcare opportunities for all

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citizens. The growing need to ensure basic services to all of America's citizens is evident. The number of Americans requiring health and rehabilitation services continues to increase due to an aging population, disabling conditions, improved treatment services, and greater survival rates. The need to access a broad range of services, therefore, is crucial. The intent should be the expansion of effective treatment options as standard services under a national healthcare program. Recreational therapy should be included as a viable option to meet the needs of consumers enrolled in the healthcare system. Ultimately, the availability of greater healthcare options which respond to the unique treatment needs of individuals with illness and disabilities will prove cost-effective. Inclusion of a comprehensive system that responds to individual healthcare consumer needs will reduce the length of hospital stay, reduce hospital recidivism, and maximize on the productivity of the individual. Recreational therapy has been and should continue to be included as an effective treatment discipline in the provision of quality, cost-effective healthcare services.

We further request that the following modification be made to the health care legislation:

In Sec. 1112 (c)(2) (Health Professional Services) line 12 after the words "are provided" add "or by a health care practitioner credentialed by professional credentialing body accredited by the National Organization for Competency Assurance."

In Sec. 1123 (a)(1) line 9, after the word "physical therapy;" add "(3) outpatient recreational therapy; and (4) outpatient speech..."

Mr. Chairman and members of the committee, the American Therapeutic Recreation Association welcomes the opportunity to present this position. Recreational therapy is an economical, active, and viable treatment option designed to enhance the functional independence of the individual to promote community independence and to enhance the quality of life of persons with illness and disabilities. We request that you include recreational therapy as an option for all Americans under the standard benefits package and look forward to answering your questions.

STATEMENT OF PETER M. DOCKX
LEGISLATIVE AFFAIRS DIRECTOR

CITIZENS COMMISSION ON HUMAN RIGHTS

Chairman Waxman, Mr. Bliley and distinguished members of the Subcommittee:

I am pleased to appear before you to offer comments on the mental health provisions of the Health Security Act of 1993.

My name is Peter M. Dockx and I am the Legislative Affairs Director for the Citizens Commission on Human Rights, for which I have worked for the past seven years.

The Citizens Commission on Human Rights (CCHR) is an international organization which has been investigating and exposing psychiatric violations of human rights since 1969, when it was established by the Church of Scientology. CCHR was recognized in 1986 by the United Nations for its work internationally to reform the field of mental health and preserve the rights of individuals under the Universal Declaration of Human Rights.

Our commission is very concerned about the extensive mental health benefits proposed in the Health Security Act of 1993 for several reasons, but the foremost is cost.

According to documents obtained from various organizations, the costs of covering mandated mental health in the fashion that President Clinton envisions will be astronomical! We are asking Congress not mandate mental health coverage for all Americans, given the fact that a recent survey showed that only 22.5% of Americans have ever consulted a mental health professional, but to make it an optional benefit for those who want it.

A 1992 study by Blue Cross Blue Shield revealed that when individual states mandated health coverage, one of the most expensive individual benefits was estimated to be mental health services. Businessmen will find it very difficult to cover 80% of the premiums for health care for their employees, especially if very expensive psychiatric care is included.

Mr. Chairman, we are urging members of this subcommittee and members of other committees and subcommittees who will be dealing with the health care reform issue to institute cost containment measures including non-payment of any ineffective psychiatric services based on unbiased "outcomes studies" including patient "satisfaction surveys".

Also, we are urging you to implement stiff federal criminal penalties for psychiatric insurance fraud. We believe these measures will save the country billions in health care costs and increase the quality of care.

I have submitted for the record a copy of an Executive Summary which our commission has prepared that gives an indication of what the true costs of mandating mental health will be. The Argument Against Mandated Mental Health Coverage: How Greed, Fraud and Abuse Will Bankrupt The Health Care System covers cost information culled from various sources such as Blue Cross Blue Shield, A. Foster Higgins, Hewitt Associates, American Psychiatric Association, the former House Select Committee on Children, Youth and Families and the U.S. Department of Health and Human Services.

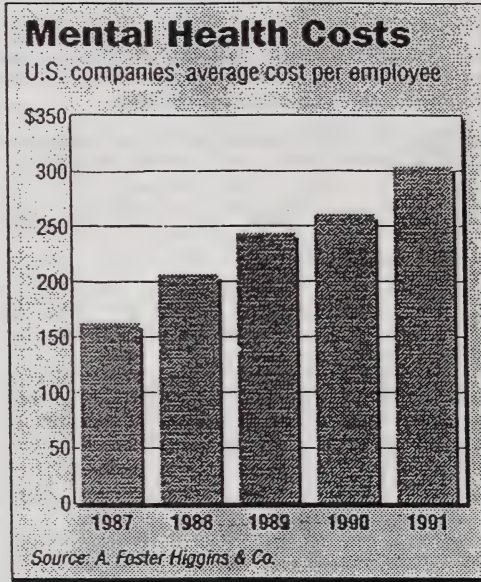
Just one quote from this Executive Summary sums up what we face as a nation should mental health be part of a mandated benefits package:

"...mandates typically increased utilization, resulting in higher total cost." - Blue Cross Blue Shield Association - Impact of State Basic Benefit Laws on the Uninsured.

Again, thank you for this opportunity to express our commission's concerns about this very important issue.

THE ARGUMENT AGAINST MANDATED MENTAL HEALTH COVERAGE:

**HOW GREED, FRAUD AND ABUSE
WILL BANKRUPT THE HEALTH CARE SYSTEM**



EXECUTIVE SUMMARY

According to the Health Insurance Association of America, typical insurance plans now cover 33 days of psychiatric inpatient care, but President Clinton's "limited" mental health coverage will cover up to 60 days inpatient care by 1998, then unlimited inpatient care by the year 2001! For outpatient psychotherapy, the typical plan now covers 90 visits a year, but the Clinton plan will cover unlimited visits by the year 2001!

Contained herein is a brief summary of relevant documents which show that the psychiatric profession is the last field which should be trusted with a blank check from the Federal Government, i.e. "mandated mental health coverage."

GOVERNMENT RECOGNIZES PSYCHIATRIC FRAUD AND ABUSE

January 1986 - A 1985 U.S. Department of Justice Report cited a disproportionate number of the physicians kicked out of Medicare and Medicaid programs for fraud and abuse were psychiatrists. While psychiatrists made up 8 percent of the physicians in the United States, they accounted for 18 percent of the physicians suspended from Medicare and Medicaid over a 15 year period. This was the worst performance of any group within the medical field.

BUSINESSES RECOGNIZE THE NEED TO LIMIT MENTAL HEALTH COVERAGE

October 1986 - Hewitt Associates - Survey of Company Practices in Mental Health Coverage - "Of the 93% of survey companies that reported that mental health benefits are covered under the medical plan and subject to a set of limits specific to mental health coverage, 71% reported specific limits for both inpatient and outpatient treatment."

COST OF HEALTH CARE HIGHER FOR MENTAL/SUBSTANCE ABUSE TREATMENT

May 1989 - Blue Cross and Blue Shield of Tennessee (BCBST) - Mental Health Utilization - "An examination shows that mental health patients and their families consume an inordinate amount of health care services: 1.5 to 2 times the amount of professional ambulatory care, when compared to other health consumers."

"Between 1986 and 1987 BCBST experienced an overall decrease in days per 1,000 enrollees. The experience for both Psychiatric and Substance Abuse was contrary to this trend. Psychiatric days per 1,000 enrollees increased by 7.7 percent; Substance Abuse days per 1,000 enrollees rose 36.8 percent."

"Average payments in 1987 associated with psychiatric patients and their families were slightly over twice the average payments for patients and families not having psychiatric admissions."

"Average payments associated with Substance Abuse patients and their families were 1.5 times higher than the average payments for patients and families not having substance abuse admissions."

"Recidivism was a factor in psychiatric experience. Recidivists comprised 17.6 percent of the psychiatric patients and 37.7 percent of the payments."

"The average professional ambulatory payment for mental health patients was 3.6 times higher than the average payment for other patients. When total family expenditures were examined, the average payment per family with mental patients was 3.1 times higher than the average payment per family with no mental health patients."

BUSINESSES FIND IT DIFFICULT TO MANAGE COSTS FOR MENTAL TREATMENT

1989 - A. Foster Higgins - Health Care Benefits Survey 1989 - Mental Health and Substance Abuse Benefits - "52 percent of the survey participants responding to questions about costs said they were unable to determine expenditures for mental health benefits. 76 percent of employers with fewer than 500 employees were unable to measure their mental/substance abuse experience."

"Most large organizations, however, fared far worse than these figures suggest. While costs remained relatively flat for employers with fewer than 5,000 employees, employers with 5,000 employees or more experienced an average cost increase of 47 percent and per employee costs averaging \$297."

RAMPANT FRAUD AND ABUSE IN THE PSYCHIATRIC SYSTEM

April 14, 1991 - ST. PETERSBURG TIMES - "Thousands of people have been hospitalized for psychiatric treatment they didn't need," said Jim Kent, vice president of Mental Health Programs Corp., a managed care company in Tampa.

"Based on review of patient records, as much as 80 percent of adolescents and 50 percent of adults admitted do not need to be hospitalized, Kent said."

"The ultimate driving force is the profit motive," Kent said.

"There is such flagrant abuse...[T]hese patients are being damaged and ripped off mentally," said Charlotte Sudakov, a nurse who reviews cases for the Managed Health Network in Los Angeles.

"Although insurance companies were tightening rules for medical and surgical care, they usually did not challenge psychiatric bills."

"Faced with high bills for thousands of patients, mental health insurance costs went through the roof. In 1989 alone, the cost for psychiatric benefits increased by 47 percent, shows a study by A. Foster Higgins & Co., a benefits consulting company. Those costs were passed along to virtually everyone who pays health insurance."

COSTS FOR PSYCHIATRIC TREATMENT SKYROCKETED IN 1980'S

May 20, 1991 - MODERN HEALTHCARE - "Costs per enrollee for psychiatric treatment, including substance abuse, rose 12.7 percent to \$1,152 in 1988 from \$1,022 in 1986, according to the latest data available from the American Psychiatric Association."

BUSINESSES FIGHT TO KEEP COSTS DOWN

December 5, 1991 - NEWSDAY - "A recent nationwide survey by A. Foster Higgins found that 87 percent of employers limited benefits for inpatient psychiatric treatment of mental disorders and substance abuse treatment in 1989, up from 75 percent in 1988. And more than half had begun limiting the amount that could be spent on inpatient care over a lifetime, a \$50,000 cap is typical."

"It now costs \$100 to \$200 an hour to visit a psychiatrist in the New York Metropolitan area, compared to \$30 to \$50 per visit to see a general practitioner - although a GP can see three or four patients in an hour. And hospitalization in a private psychiatric hospital can cost as much as \$1,000 a night."

"Companies that neither switched to managed care nor put limits on inpatient costs for these treatments spent \$282 per employee on claims, or 23 percent more than those that had limits," the consulting firm A. Foster Higgins said.

"The costs for psychiatric care and substance abuse were increasing at double the rate of our other health-care costs," said IBM spokesman Pat Stenson.

"The insurance industry says these fields have a high incidence of unnecessary treatments. While there have been no national studies reviewing inappropriate admissions in mental health, a study done this year by Blue Cross/Blue Shield of Michigan found that 38 percent of the days patients spent in hospitals for mental and substance abuse treatment appeared to be unnecessary. The study, whose findings were based on 539 cases at 61 hospitals, concluded that many patients did not have to be admitted or were well enough to be discharged earlier and be treated on an outpatient basis."

CONGRESS INVESTIGATES PSYCHIATRIC FRAUD AND ABUSE

April 17, 1992 - Hearing by the House Select Committee on Children, Youth and Families - Texas State Senator Mike Moncrief stated, "We have uncovered some of the most elaborate, aggressive, creative, deceptive, immoral and illegal schemes being used to fill empty hospital beds with insured and paying patients."

Chairwoman Pat Schroeder's opening statement included these remarks: "The nationwide investigation conducted by the Select Committee...found unethical and disturbing practices in inpatient psychiatric care from coast to coast. The following are but a few of the shocking revelations that have been uncovered: Thousands of adolescents, teenagers, and adults have been hospitalized for psychiatric treatment that they didn't need; Hospitals that hire "bounty hunters" who 'kidnap' patients with mental health insurance; patients kept against their will until their insurance benefits ran out; psychiatrists being pressured by the hospitals to alter their diagnosis to increase profits; bonuses paid to hospital employees, including psychiatrists, for keeping the hospital beds filled; and military dependents being targeted for their generous mental health benefits."

"According to a briefing I received from the Department of Justice, current intelligence shows that psychiatric hospitals and clinics are defrauding Government programs and private insurers of hundreds of millions of dollars annually. Patients have been forcibly admitted into psychiatric treatment programs in situations where they posed no threat to the community of themselves. Investigations by the FBI to date have disclosed billings to the Government in the hundreds of millions of dollars."

STATE MANDATES FOR MENTAL HEALTH CREATED "BOOM" FOR PSYCHIATRY

1992 - Mental Health, United States, 1992 - U.S. Department of Health and Human Services - "The number of beds in separate psychiatric inpatient services of non-Federal general hospitals rose slowly but steadily between 1970 and 1980, from 22,394 to 29,384, but increased substantially during the 1980's to 48,421 beds in 1988."

"Expenditures in private psychiatric hospitals increased dramatically between 1969 and 1988, reaching almost \$4.6 billion, or more than 20 times the expenditures of \$220 million in 1969."

MANDATES TYPICALLY INCREASED UTILIZATION

December 1992 - Blue Cross Blue Shield Association - Impact of State Basic Benefit Laws on the Uninsured - "...[W]hile the cost of a particular benefit may not be large, available evidence indicates the cumulative cost of multiple mandates can be very large. A new survey of Blue Cross and Blue Shield Plans indicates that the added

cost of mandates varies significantly from state to state."

"The most expensive individual benefits were estimated to be substance abuse treatment services and mental health care services."

"The cost magnitude reported in the survey is generally consistent with independent studies that have measured the effect on premiums of state mandated benefits."

"The survey also queried Blue Cross and Blue Shield plans as to whether the existence of mandated benefits has resulted in net savings by shifting the delivery of services to a more cost-effective setting or health-care provider. All but two of the respondents said in their experience, mandates typically increased utilization, resulting in higher total cost."

"In Maryland, for instance, the Blue Cross and Blue Shield plan found that outpatient mental health care visits rose dramatically once coverage for them was expanded under the mandate, from 448,000 in 1983 to 800,000 in 1986, and average growth rate of 21% per year. There was no offsetting decline in the utilization of inpatient mental health care services."

MORE THAN 600 AGENTS FROM FBI AND OTHER FEDERAL AGENCIES RAID HOSPITAL CHAIN LOOKING FOR EVIDENCE OF CRIMINAL MISCONDUCT

August 27, 1993 - WALL STREET JOURNAL - National Medical Facilities Raided By U.S. Agents - "The probe, one of the largest ever against a hospital company, is the latest sign of the government's heightened interest in health-care fraud and abuse."

"The widening government probe could include allegations that the company paid 'bounty hunter' fees to obtain psychiatric patients and misdiagnosed patients so it could increase insurance recoveries, analysts said."

"Besides the FBI, agencies involved in the investigation... include the Inspector General's Office of the Department of Health and Human Services, the Defense Criminal Investigative Service, the Postal Inspection Service and the Internal Revenue Service."

AS THIS EVIDENCE SHOWS, IF THE FEDERAL GOVERNMENT MANDATES MENTAL HEALTH COVERAGE FOR ALL AMERICANS, THE PSYCHIATRIC PROFESSION WILL ATTEMPT TO MAXIMIZE THE UTILIZATION OF THOSE BENEFITS, WHETHER PATIENTS NEED TREATMENT OR NOT, AND THE COST OF HEALTH CARE IN AMERICA WILL SPIRAL EVEN FURTHER OUT OF CONTROL.

**Testimony to the
Health and the Environment Subcommittee
of the Committee on Energy and Commerce
on the Mental Health Provisions of HR 1757
The Health Security Act of 1993**

COALITION OF ORGANIZATIONS

Submitted by:

American Academy of Child and Adolescent Psychiatry
American Association for Marriage and Family Therapy
American Association for Partial Hospitalization
American Association of Children's Residential Center's
American Association of Pastoral Counselors
American Association of Psychiatric Services for Children
American Association of Private Practice Psychiatrists
American Counseling Association
American Family Foundation
American Occupational Therapy Association
American Psychiatric Association
American Psychiatric Nurses Association
American Psychoanalytic Association
American Psychological Association
American Society for Adolescent Psychiatry
Anxiety Disorders Association of America
Association for the Advancement of Psychology
Bazelon Center for Mental Health Law
Children and Adults with Attention Deficit Disorders
Child Welfare League of America
Cult Awareness Network
Family Service America, Inc.
Federation of Families for Children's Mental Health
International Association of Psychosocial Rehabilitation Services
National Association for Rural Mental Health
National Association of Counties
National Association of Homes and Services for Children
National Association of Psychiatric Treatment for Children
National Association of Protection and Advocacy Systems
National Association of Social Workers
National Association of State Mental Health Program Directors
National Community Mental Health Care Council
National Depressive and Manic Depressive Association
National Federation of Societies for Clinical Social Work
National Foundation for Depressive Illness
National Mental Health Association
National Organization of State Associations for Children
Society for Education & Research in Psychiatric-Mental Health Nursing

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TESTIMONY TO THE
HEALTH AND THE ENVIRONMENT SUBCOMMITTEE
OF THE COMMITTEE ON ENERGY AND COMMERCE
ON THE MENTAL HEALTH PROVISIONS OF HR 1757,
THE HEALTH SECURITY ACT OF 1993
DECEMBER 8, 1993

Chairman Waxman, Mr. Bliley, Members of the Committee:

The undersigned mental health organizations are pleased to present our views on mental health provisions in the Health Security Act. Thank you for making our views part of the record of the hearing you held on December 8.

The hearing permits us to examine the mounting evidence that mental health benefits are a sound investment in the healthcare of our nation and to correct erroneous notions about the cost and effectiveness of mental health treatment. It also provides us the opportunity to evaluate HR 1757, the Administration bill introduced on November 20, from the viewpoint of people who need mental health services.

We commend the President and Hillary Rodham Clinton for their leadership in bringing healthcare reform to the fore. And we want particularly to acknowledge the valiant efforts of Tipper Gore, who headed the work group on mental health and has been an ardent and eloquent champion of mental health services from the beginning.

Our Position on Mental Health Benefits in Health Care Reform Legislation

Our position is clear and explicit: mental health care must be an integral part of healthcare reform. Some of us may emphasize one element of the overall benefit and some another, according to the needs of our particular constituencies. But we stand united behind the following principle: Mental health benefits must be provided through a system of organized care, with a full continuum of services, and must not be subject to arbitrary limits in amount or duration of services which are not imposed on other healthcare benefits. The position has found significant support in Congress. Over 218 members of the House and 18 Senators have endorsed concurrent resolutions calling for parity and the inclusion of a comprehensive mental

health benefit within any healthcare reform initiative.

Without a comprehensive flexible array of mental health services, the basic benefits package will neither serve the essential needs of the population nor be cost effective. We ask you to soundly reject the spurious reasoning that argues against comprehensive mental health coverage. Much of it is based on conditions which no longer exist and assumptions that are badly outdated. This coverage is far too important to our nation and to the millions of people who suffer from mental disorders to allow it to be buried under the dust of antiquity.

The Positive Elements in the Health Security Act of 1993

The Clinton plan has many broad features that are clearly in the best interests of the general public as well as people with mental disorders. Most importantly, it assures universal coverage to all lawful residents regardless of income and job status. In disproportionate numbers people with serious mental illnesses now are without health coverage at all because they are not in the work force.

Further, the proposal eliminates annual and lifetime dollar limits on healthcare services, abolishes pre-existing condition exclusions, includes coverage for assessment, diagnosis and crisis intervention, creates a new community-based long-term care program, and stresses prevention and early intervention. These aspects of the plan are tremendously important to our constituencies. We also recognize the significant value of the overall benefits package to the populations for which we advocate. After all, individuals with mental illnesses get other illnesses too.

The Administration's proposal makes mental health services an integral part of the basic benefits package. It clearly articulates the principle of parity between the treatment of mental illness and other illnesses by committing to full comprehensive benefits without arbitrary limits on January 1, 2001, three years after the onset of the program. However, until full equity is achieved, the interim mental health benefits in HR 1757 contain severe limits on amount and duration and excessive copayments which substantially interfere with their accessibility by people with mental illness. Eligibility for mental health services should be determined on the basis of medical or psychological necessity, not by overly restrictive criteria like life endangerment. We discuss the problems with the interim benefit in more detail below.

Our Objectives for Healthcare Reform

As the deliberations around healthcare reform unfold, there are key objectives our organizations and the people they represent want Congress to pursue:

- ◆ Congress should endorse and enact the Administration's commitment to full coverage for mental health services to begin on the date of initial implementation of the plan rather than in 2001.¹
- ◆ Congress should remove the discriminatory barriers to access for low-income people with mental disorders caused by copayments and inadequate subsidies.
- ◆ Congress should add incentives to assist the integration of public and private mental health providers to end the two-tier system of care prevailing today.
- ◆ Congress should assure that each health plan permits maximum consumer choice in provider selection and participation in treatment planning, confidentiality of records and due process procedures.
- ◆ Congress should require that quality assurance standards and access to services are supported by monitoring mechanisms to assure that consumers receive the amount and level of care they need.

Why Equity Now

The Clinton plan for health care reform contains a firm unequivocal commitment to comprehensive mental health services in 2001, three years after the effective date for implementing the Act. The date is not dependent on any other factor such as approval of the state plan for integrating mental health services or cost savings in the interim period. We appreciate the Administration's commitment to eventual equity. However, we urge equal treatment for mental and physical disorders when the overall program goes into effect in 1998. We agree with Senator Wellstone, who reminded us in his Roll Call article that "those in need cannot wait until 2001 for the phase-in."¹

There are compelling public policy reasons for making comprehensive benefits available from the start rather than 2001. The absence of a comprehensive benefit will perpetuate unnecessary national costs for mental illness, both within and outside the health care system. Coverage for a full continuum of mental health services is essential to ensuring access to care in the most appropriate and cost-effective setting.

¹Wellstone, P., "Mental Health Care is a Right for All, Too: But Clinton Plan Relies Too Much on Inpatient Treatment, May Make Cost Too High to Afford," Roll Call Health Care Reform Policy Briefing, October 18, 1993.

Until the phase-in occurs, care will be limited by the services covered rather than the services the patient needs. The imbalance can inflate mental health care costs over the short term and thereby fuel the arguments of some who assert that mental health services are too expensive.

The societal payoffs of effective services for people with severe mental illness are large: increased earning power, less dependency on public programs of support, reduced pressure on the correctional system, fewer social problems. Individuals and their families can be reintegrated and their personal satisfaction enhanced. Experts even project about a 10% reduction in general health care costs, as proper mental health care will reduce use of the general health system.²

The three year period between enactment of the plan in 1994 and implementation in 1998 is sufficient time for providers to develop the management capacity and procedures to properly administer a comprehensive plan. Artificial limits on care are not only costly to the consumer but unnecessary as well. The limits create disincentives to move toward a truly flexible comprehensive benefit in 2001.

Finally, we are fearful that 2001 may never arrive for those suffering from mental disorders if full implementation is delayed. The goal may be made hostage to the achievement of cost savings or other considerations that could excuse the Administration and Congress from the promise of equitable coverage.

Deficiencies in HR 1757 for People with Mental Illness

The President's interim plan for mental health services raises a number of serious problems for people with mental illness which demonstrate why a limited benefit is unworkable. We have divided our concerns into two sections, the first relates to the mental health benefit provisions; the second, to problems in other parts of the bill which have serious consequences for people with mental illness.

A. Defects in the Interim Mental Health Benefit

1. Limitations on Inpatient/Residential Services

HR 1757 permits extension of inpatient/residential services beyond 30 days only on the basis that the patient is a threat to himself or others, needs drug regimen adjustment or requires somatic therapy. These limited-bases represent interference with the patient's ability to obtain appropriate treatment. Medical

²See p. 12, fn 16-19. For example, Strain, J.J., Lyons, J.S. and J.S. Hammer, "Cost Offset from a Psychiatric Consultation-Liaison Intervention with Elderly Hip Fracture Patients." *American Journal of Psychiatry*, Vol. 148 (8) August 1991.

and psychological necessity should be the criteria for determining length of stay. The trade-off features in the benefit compound the problem. For example, after drawing down 30 inpatient days to use the first 60 days of the intensive nonresidential benefit, individuals may find they have "lost" access to the inpatient benefit because of the overly strict criteria for obtaining additional days.

2. Restrictions in Intensive Non-residential Treatment

The intensive non-residential benefit offers a bold and progressive approach to treating people with serious mental illness. However, it contains conditions which make the services difficult to access. The initial 60-days are available only on the basis of trade-offs for inpatient care. This arrangement forces individuals whose illnesses are often unpredictable to relinquish their inpatient safety net to utilize community based intensive services. The choice places an inappropriate decision burden on people with mental illness. Their conclusion is likely to be based on fear rather than clinical appropriateness.

To use the second sixty days, an individual must pay both a one-day deductible and 50% copayment. Even in the low-copay plans, using the 60 days will cost the individual \$1500, none of which counts toward the out-of-pocket limit on the individuals total health expenditures.

Further, while the benefit specifies four "treatment purposes," it also permits plans to employ their own criteria for determining who can receive services. This discretion can result in plans choosing the narrowest treatment purpose, thus further limiting access.

The combination of trade-offs and high co-payment requirements diminishes the value of this innovative approach as an alternative to more expensive inpatient care. Only if these services are fully available will consumers have a true choice to utilize the least restrictive environment.

3. Confusion on Psychotherapy Substitution

The bill attempts to offset a totally inadequate 30-visit benefit with a provision that allows health plans the discretion to substitute four outpatient psychotherapy visits for one day of hospital care to reduce or shorten hospitalization. It is unclear whether the plan's discretion applies to determining the individual situations where the substitution is applicable or the availability of substitution entirely. If the latter, the provision can create serious adverse selection problems, as discussed below. Patients who reach maximum limits on outpatient psychotherapy (as with other limited services in the bill) are faced with the same difficult

and, in some cases, life threatening situation: no coverage for needed services. Unlike any other health benefit, individuals suffering from a mental disorder are forced to accept arbitrary and discriminatory limits on care vital to their recovery.

4. Inadequate Incentives to Integrate Public and Private Systems

At the present time, there are two tiers of mental health services: the publicly funded state system which serves as a safety net for the most seriously ill; and the private system which relies on multiple funding sources, including a significant percentage of private pay patients. Together with the President, we support the integration of these two systems. Under an integrated approach, the role of the public system undoubtedly will change—probably by moving away from acute service delivery toward emphasis on support services, quality assurance and innovation. Congress should assist the process by creating incentives for states to integrate their system with the national plan while protecting those vulnerable populations who will be at risk if state mental health service dollars are diverted into other purposes. In addition, we recommend that Congress authorize the states, applying Federal standards, to designate publicly supported mental health and substance abuse programs as *essential community providers* to ensure that people in low income areas will have access to services and promote the integration of the public and private systems.

5. Cut-back on Collateral Services

The latest revision to the plan reduces the mental health benefit by including collateral services for family members within the already inadequate 30-visit limit on psychotherapy. In the October 27 draft bill, 30 visits for collateral services were in addition to psychotherapy. Visits with family members are often highly effective means for treating the individual with mental illness.

6. Barriers to Services for Children

The interim benefit creates barriers and disincentives to services for children. The requirement that the individual pose a threat to himself or others to receive residential treatment beyond 30 days is wholly inappropriate for children. Similarly, having to substitute home-based, behavioral aide or day treatment services for residential care will leave parents with seriously ill youngsters with fewer future choices. They may forego effective community treatment in order not to lose their residential safety net. The high copayments may be a particular barrier for children who are dependent on others to gain access to needed

treatment.

Instead of building barriers and disincentives, public policy should actively encourage early identification and intervention for childhood problems. The Clinton plan endorses this approach for conditions other than mental illness. The failure to do so for our children only results in devastated young lives and higher future costs as untreated problems worsen into disability.

7. Inappropriate Services for People with Dual Diagnoses

People with substance abuse disorders and mental illness are particularly at risk of undertreatment because the limits on services apply to both conditions. The needs of a dually diagnosed individual may quickly exceed the limits in the interim benefits package. The effect will be that people with substance abuse disorders and mental illness will be forced to obtain care in the overburdened public system much sooner than others not so seriously impaired. We recommend that Congress recognize the special situation of the dually diagnosed population. Only a comprehensive benefit would accurately responds to their needs.

B. Other Weaknesses of Particular Concern to People with Mental Illness

1. Caps on Premium Subsidy

The plan contains premium subsidies to low income individuals and small businesses. If the subsidies required in a given year exceed the estimates for the year, an additional appropriation is needed. We believe the failure to make the subsidy payments automatic potentially threatens guaranteed access to care. If Congress fails to enact additional revenues, the plans can pare back benefits. Given the historic stigma associated with mental illness and substance abuse, we fear these benefits will be cut first when shortfalls occur. We recommend that the legislation contain guarantees that no one can be denied any benefit under the plan because of insufficient funds for subsidies.

2. Unaffordability of Services

The poorest and the sickest among us become even more vulnerable when access to care is contingent on payment of deductibles and coinsurance. For many Americans living in the shadows of economic despair even the most minimal copayment can be prohibitive. We believe that individual responsibility is a valuable principle, but it should not become a mantra invoked to legitimize continued discrimination against low-income citizens, regardless of their disability or diagnosis. Requiring 50%

copayments for outpatient psychotherapy and intensive non-residential services and one-day deductibles, for example, represent excessive cost-sharing requirements which will inhibit access to critical services by people with mental illness.

We support a sliding scale for copayments to help low income people, with adequate subsidies to prevent premiums, deductibles, and coinsurance from becoming barriers to appropriate care. In addition, we believe all copayments and deductibles for mental health services should be counted toward the out-of-pocket limit, just as they are for all other benefits in the plan.

3. Inadequate Quality Standards for Delivery of Services

Individuals with chronic illness, both mental and physical, are at risk of being denied essential services in managed care settings. The experience with HMOs in limiting care to people with severe mental illness demonstrates that providers operating under capitated premiums have strong incentives to undertreat high cost patients.

Health care reform legislation should not create a culture in which clinically necessary services are inappropriately denied or are approved too late. Instead the legislation should emphasize early intervention, quality assurance standards and effective monitoring to assure that consumers receive services in the amounts and settings appropriate to their conditions.

4. Potential for Adverse Selection

We anticipate that some health plans will provide their enrollees with better mental health care either by offering four additional outpatient psychotherapy visits for one inpatient day if the additional treatment would prevent or reduce hospitalization, or by providing more effective or higher quality mental health services overall. Other plans may begin to move toward the 2001 goal of comprehensive benefits earlier. The "better" plans will naturally attract more people with mental illness. However, the Clinton proposal would penalize these plans because of the vague rules on risk adjustments for plans who have higher costs. We recommend that plans which have higher costs because of the flexibility of their benefits or the quality of their services be clearly eligible for cost adjustments.

5. Strictness of Long-Term Care Eligibility Criteria

We are pleased that the proposed eligibility criteria for the home and community-based long-term

care benefit reflects an understanding of the need to use different approaches to determining eligibility for physical and mental disabilities. However, the eligibility criteria are set at a level of severity that permits only people with extreme dysfunction of a chronic nature to receive services. The eligibility rules do not recognize the cyclical nature of the active symptoms of mental illness. We recommend that the criteria recognize that people with serious, persistent mental illness may need long-term support services on an intermittent basis.

These are serious problems areas for people with mental illness. They represent challenges to the Congress to correct the significant flaws in the Administration's plan, to enrich it and move it to the next level where true parity between mental health and physical health can be realized.

The Magnitude of the Mental Illness Problem in the United States

An enormous number of people are affected by mental health problems and will benefit from comprehensive mental health coverage. An estimated 41.4 million adults have had a mental disorder at some time in their lives³ and about 7.5 million children suffer from mental and emotional disturbances such as depression, autism and attention deficit disorder.⁴ We also know that about one-fifth of those afflicted with AIDS will develop AIDS-related cognitive dysfunction and two-thirds will develop neuropsychiatric problems.⁵ These are people who often cannot obtain mental health services under the current system. Only about one-third of the children and adolescents who need treatment ever receive it.⁶ Among adults, one out of six individuals with serious mental health problems gets needed care.⁷ And one need only look

³Bourbon, K. H.; Rae, S.; Locke, Z.; Narrow, E.; and Regier, D., "Estimating the Prevalence of Mental Disorders in U.S. Adults from the Epidemiologic Catchment Area Survey," *Public Health Reports*, Vol. 107, No. 6, November-December, 1992.

⁴U.S. Congress, Office of Technology Assessment. *Children's Mental Health: Problems and Services—Background Paper*, OTA-BP-H-33 (Washington, DC: U.S. Government Printing Office, December, 1986).

⁵Detmer, W.M. and F.G. Lu, "Neuropsychiatric Complications of AIDS: A Literature Review," *Intl. Psychiatry in Medicine*, Vol. 16 (1) 1986.

⁶U.S. Congress, Office of Technology Assessment, op. cit.

⁷Manderscheid, R. et al., "Congruence of Service Utilization Estimates from the Epidemiologic Catchment Area Project and Other Sources," *Arch of Gen. Psychiatry*, Vol. 50 February, 1993.

under the nearest bridge to see homeless persons with mental illness with no access to mental health services. Persons with significant mental health problems are legion within the ranks of the uninsured and the underinsured. And even those fortunate enough to have insurance coverage too often find their treatment limited by lifetime or annual limitations, discriminatory copayments, and other cost containment devices that eke financial savings out of the mental torment of the afflicted.

We cannot afford to write off so many of our people by excluding or only minimally covering mental health services in the reformed health care system. It is a matter of justice and it makes good economic sense to assure access to needed mental health treatment.

Untreated Mental Health Problems Exact a High Price

Consider for a moment the costs currently borne by society because mental health coverage is so woefully inadequate. Nearly a third of the nation's homeless persons have a severe mental illness.⁸ A majority of the 30,000 suicides in America each year can be attributed to a mental or addictive disorder.⁹ Major depression accounts for more bed days (people out of work and in bed) than any impairment except cardiovascular disorders.¹⁰ Persons with job-related stress, anxiety and depression miss an average of 16 work days per year. Persons with untreated mental illnesses consume almost twice as much medical care as the average individual.¹¹ Add to the mix the thousands of persons with mental illnesses who are denied treatment, but instead languish in high-cost prison and jail cells. Add in the costs of unfulfilled human promise, education not pursued, work not obtained, contributions to society not made. These human costs are monumental; even in hard dollars and cents, they are staggering. The costs associated with SSI, SSDI,

⁸Interagency Council on the Homeless, *Outcasts on Main Street: Report of the Federal Task Force on Homelessness and Severe Mental Illness*, (ADM) 92-1904, Washington, DC: 1992.

⁹National Center for Health Statistics, Public Health Services, U.S. Dept. of Health and Human Services 1993. Unpublished data from Division of Vital Statistics.

¹⁰National Advisory Mental Health Council, *Health Care Reform for Americans with Severe Mental Illness: Report of the National Advisory Mental Health Council*, Rockville, Maryland: National Institute of Mental Health, 1993.

¹¹Borus, J.F., Olendski, M.C., et al., "The Offset Effect" of Mental Health Treatment on Ambulatory Medical Care Utilization and Charges," *Archives of General Psychiatry*, Vol. 42, June, 1985.

welfare programs, incarceration, and divorce are equally enormous—estimated at \$74.9 billion in 1990. These costs are being paid every day, by people like you and me. They are being paid out in the human tragedies wreaked on families and their relatives with mental illnesses. Coverage limits so prevalent private insurance today can shift catastrophic costs onto families, forcing many into bankruptcy or long term indebtedness. Lack of options can force persons into hospitalization, when broader coverage could permit them to be more appropriately and more cheaply treated in the community. Or worse, lack of comprehensive benefits delays needed treatment until a crisis occurs.

The Effectiveness of Mental Health Treatment

All relevant research tells us that mental health treatment is effective. A whole new armamentarium of interventions available for treatment has emerged since President Kennedy launched the community mental health movement in 1963. Medications like lithium and clozapine have worked miracles for some patients, while others have experienced dramatic success through psychotherapy, psychiatric rehabilitative programs, residential treatment, partial hospitalization, crisis intervention, day treatment, and in-home services. For most persons, the days are gone when long-term hospitalization and custodial care were the only services utilized. Today, most mental disorders can successfully be treated without hospitalization. Community based intensive treatment programs and services, such as psychiatric rehabilitation and partial hospitalization, have been shown to have a positive long term effect of significantly reducing hospital utilization, increasing the level of functioning and improving the individual's quality of life. Nearly 80% of patients with manic depression can be restored to essentially normal lives. Outpatient treatment for anxiety disorders is both effective and relatively inexpensive. Most schizophrenia symptoms can now be controlled, significantly reducing the relapse rate of patients.¹² And companies around the nation are also discovering that relatively minimal mental health interventions can dramatically increase worker productivity and reduce absenteeism.

Mental Healthcare is a Good Investment

Mental healthcare is not as expensive nor are the costs rising as rapidly as many other sectors.

¹²National Advisory Mental Health Council, op. cit.

¹³Ibid.

health care. Three independent studies between 1971 and 1985 found that mental health costs have remained relatively constant over the last 20 years, ranging from 9-11 percent for total treatment costs.¹⁴ When combined with substance abuse treatment, mental healthcare ranks 25th in the factors influencing the increase in health care costs.¹⁵

Good mental healthcare is also a good deal because it can help reduce other physical healthcare costs. One investigator found that untreated persons with panic disorders mimicked heart patients and were often misdiagnosed and subjected to needless, ineffective, and expensive treatments.¹⁶ Other studies have shown that general inpatient medical care can be cut by as much as 70% following mental health treatment, and outpatient utilization can be lowered by 20%.¹⁷ In a study of the Federal Employees Health Benefits Plan, patients with chronic medical diseases who received psychotherapy used 56% fewer medical services than those who did not receive psychotherapy.¹⁸ The National Institute of Mental Health has estimated that general medical costs could be reduced by as much as \$1.2 billion through the use of associated mental health treatment.¹⁹ These savings make mental healthcare a sound investment--especially when mental health services are well managed.

¹⁴Ibid. See also, Rice, D.P., Kelman, S., Miller, L.S., et al., *Economic Costs of Alcohol and Drug Abuse and Mental Illness: 1985*, DHHS Pub. No. (ADM) 90-1694, Rockville, Maryland, ADAMHA, 1990; Harwood, H.J. and Napolitano, D.M., et al., *Economic Costs to Society of Alcohol and Drug Abuse and Mental Illness: 1980*, Research Triangle Park, North Carolina, Research Triangle Institute, 1984; and Cruze, A.M., et al., *Economic Costs to Society of Alcohol and Drug Abuse and Mental Illness, 1977*, Rockville, Maryland, ADAMHA, 1981.

¹⁵Modern Health Care's compendium of Cost Factors; Coddington.

¹⁶National Institute of Mental Health, Memorandum from Alan Leshner, Deputy Director, Concerning cost-effectiveness of mental health services, Rockville, Maryland, 1993

¹⁷Mumford, E., and H.I. Schlesinger, et al. "A New Look at Evidence About Reduced Cost of Medical Utilization Following Mental Health Treatment," *American Journal of Psychiatry*, Vol. 141 (10) October, 1984.

¹⁸Schlesinger, H.J., Mumford, E., Glass, G.V., et al., "Mental Health Treatment and Medical Care Utilization in a Fee-For-Service System: Outpatient Mental Health Treatment Following the Onset of a Chronic Disease," *American Journal of Public Health*, Vol. 73 (8) April, 1983.

¹⁹National Advisory Mental Health Council, op. cit.

Managed Care and Mental Health

Managed care is an area in which the mental health community has substantial experience, both good and bad. An estimated 48 percent of people with health insurance are already enrolled in some type of managed behavioral health program.²⁰

We appreciate that care management is a central feature of the cost containment strategies in the healthcare reform plan. As we describe above, we are concerned that care be managed properly so that consumers receive services in amounts and settings appropriate to their conditions. We know this can be done.

Many large businesses (like Honeywell, Chevron, Pacific Bell, and IBM) now know that managed care techniques are as effective--and often more effective--than the imposition of arbitrary and discriminatory limits on mental health care. For example, McDonnell Douglas Helicopter Company realized a decline in per capita costs of 34% under a managed mental health benefit, including a 50% reduction in psychiatric inpatient costs. First National Bank of Chicago removed its mental health coverage limits and also reduced inpatient costs by 50% over five years under a managed care approach.²¹ We believe the Congress should take notice of such experiences and build upon their successes by removing all discriminatory barriers to mental health services once and for all.

Seize the Moment Before It Passes

Skeptics might question whether it is feasible to improve upon the President's benefit package at a time when cost considerations are so prominent. But we assert that it is not only feasible, it is also prudent. The availability of a broad array of community based mental health services can produce the offset in costs indicated by research. The sooner these services become fully available, the sooner the savings will be realized. Major businesses have achieved significant offsets and savings by eliminating discriminatory features in the plan design and permitting the mental health benefit to be managed on the basis of medical necessity. Their experience should weigh heavily in your judgments, because it reflects a broader reality

²⁰Open Minds. Managed Behavioral Health Market Share in the United States, Gettysburg, PA, 1993.

²¹McDonnell Douglas Corporation. *McDonnell Douglas Corporation Employee Assistance Program Financial Offset Study: 1985-1989*, St. Louis, MO: McDonnell Douglas Corporation and Alexander Consulting Group, 1990; Washington Business Group on Health.

than a narrow technical perspective dominated by arcane rules for "scoring" savings. The offsets demonstrated through research and real-world application have greater validity than conjectural and abstract mathematical calculations.

The time to fix flaws and address known problems is now. With the House Working Group on Mental Health/Mental Illness and its Senate counterpart, and the members of this Committee, the mental health community is fortunate indeed. We look forward to working closely with all of you and your colleagues in helping to shape the mental health benefit to serve the needs of our people.

Statement Submitted To

Health Subcommittee
Committee on Energy and Commerce
U.S. House of Representatives

Hearings Concerning
Health Care Reform

December 8, 1993

On Behalf Of:

American Academy of Child & Adolescent Psychiatry
American Occupational Therapy Association
American Psychiatric Association
American Association of Children's Residential Centers
Bazelon Center for Mental Health Law
Child Welfare League of America
Children's Defense Fund
Council for Exceptional Children
Family Service America
Federation of Families for Children's Mental Health
National Association of Homes & Services for Children
National Association of Psychiatric Treatment Centers for Children
National Association of State Mental Health Program Directors
National Council of Community Mental Healthcare
National Education Association
National Mental Health Association
National Organization of State Associations for Children
Washington Business Group on Health

The 18 national organizations listed above submit the following statement for the record. Our statement highlights the needs of children and adolescents with mental and emotional disorders and urges the Congress to protect these children's interests as the Health Security Act moves forward.

Children and adolescents with mental and emotional disorders now have no assurance that their illnesses will be identified, evaluated, diagnosed or treated. Many have no insurance, others are underinsured or covered by benefit packages that discriminate against mental and emotional illnesses. Without adequate insurance and without appropriate access to treatment these youngsters' lives are in jeopardy and many are destined to face long-term, costly consequences -- both social and financial. The President's Health Security Act, while addressing the problem of access, falls far short in meeting the service needs of children and adolescents needing mental health services in its initial, limited mental health benefit package.

While we applaud the President's inclusion of a fully comprehensive, flexible benefit in 2001, we do not believe it is necessary to wait into the next Century to provide the coverage children and adults so clearly require.

While the President is to be commended for proposing coverage of a broad array of services, we are extremely concerned about the impact of the arbitrary limits and the trade-offs which are proposed for the initial benefit. Until 2001, the President's plan will effectively eliminate the advances made recently in the delivery of mental health service delivery system for children because of restrictive and unrealistic limits on care and a system of trade-offs between benefits which is both detrimental to access and further erodes the limited benefit. What we will see is a service delivery system that continues to pay too little attention to clinical need. Removing the artificial limits would require health plans to assume full responsibility for these youngsters and motivate them to intervene early.

The following data highlight both the current problems in the system and the promise for a very different set of outcomes if we alter current reimbursement practices.

Our organizations urge the Congress to closely examine the data summarized here. We believe that Congress should include *in the basic benefit of the Health Security Act* the cost-effective mechanisms described below, so as to provide children and adolescents a full range of comprehensive mental health services which can be accessed as and when needed.

We can no longer tolerate the current situation, where lack of access by children and families to treatment is devastating children and adolescents, and resulting in long-term problems which cost our society billions of dollars in other social welfare programs. The inappropriate treatment of children also results in a possible *lifetime* of unnecessary distress and under-productivity.

Prevalence of Mental Disorders Among Children and Adolescents

Approximately 20% of all children and adolescents have a diagnosable mental disorder (Costello, 1989; Knitzer, 1982). About 3-5% of children suffer from severe mental disorders (MECA, 1993). Those children with severe disorders will require access to treatment through a full range of service options, particularly options that enable them to continue to live at home with their families. Many of these options have traditionally not been available through insurance plans.

In addition, the incidence of mental and emotional problems among children and youth in the care of various state administered systems are simply shocking. For example, somewhere between 50% and 85% of the 430,000 children in our nation's foster care system have a diagnosable mental or emotional disorder. Similarly, it is estimated that over 60% of the approximately 94,000 adolescents detained in juvenile justice facilities across the country have substantial mental health or substance abuse problems, while state special education programs serve over 390,000 children with serious emotional disturbances.

Lack of Access to Services

Studies have found that a significant proportion of the children with mental and emotional illnesses do not have access to services. Between 70-90% of children with severe disorders are not receiving mental health services, and only 2-6% of all children with mental or emotional disorders receive some form of mental health care (Costello, Angold, Burns & Leaf, 1992; MECA, 1993, Burns, 1990 and Bickman, 1993).

Prevention and early intervention services have been underfunded and relatively unavailable in the foster care and juvenile justice systems. In many instances, children receive direct services only after mental health problems have become manifest.

Appropriate Services for Children

Calls for the development of comprehensive, community-based systems of care for children with mental health disorders date back to the Joint Commission on the Mental Health of Children in 1969. The Commission's report found that these children were typically unserved or served inappropriately because of the lack of available models of appropriate care. These findings have since been substantiated by numerous studies, task forces, commissions and reports -- including reports from the Office of Technology Assessment and the Institute of Medicine -- all of which concurred that coordinated systems of care providing a broad range of services are required to meet these youngsters' needs.

Systems of care emphasize comprehensive and individualized services, furnished within the least restrictive most appropriate environment, with the full participation of families. The coordination among public child-serving agencies and programs is also a quintessential ingredient in the provision of appropriate care to these young people. The system of care approach represents not only a network of services, but a philosophy about the way in which services should be delivered, based on the individual needs of the child and family.

Despite a ten-year federal demonstration program (Child and Adolescent Service System Program, CASSP), which evidenced the effectiveness of such systems of care, it has only been relatively recently that any examples of this approach have emerged. Such systems have begun to blossom around the country as federal, state and local governments, as well as foundations, have sponsored activities in this field.

There currently is widespread consensus that community-based systems of care represent the state-of-the-art in treating children with serious emotional disorders, and the development of such systems has become a national goal. Indeed, this Committee led the way in approving the Child Mental Health Services Program in 1992, to stimulate the development of such systems in states and communities across the country (enacted as part of PL 102-321, the ADAMHA Reorganization Act).

It is especially important now, as Congress considers the issue of health care system reform, to examine what we are learning about systems of care for children and to ensure that the reformed health care system represents true reform -- reform that encourages the provision of the most appropriate care for children and youth with mental and emotional disorders, in a flexible manner, based on clinical needs.

Data on Comprehensive Services for Children

Comprehensive, managed systems of care (or managed benefits) for children with mental and emotional disorders can be found in the private and public sectors.

In the private sector, many large company health care plans now include a comprehensive and flexible managed benefit that includes inpatient services, residential treatment, day treatment and outpatient care. Experience with these plans generally shows that the comprehensive and flexible approach is preferable and more cost-effective than a traditional insurance benefit.

In the public sector, through public funds or private foundation support, several systems of care are now operating. Some, such as the Robert Wood Johnson foundation's children and youth project, target children with the most severe disorders, while others target a broader population. According to a recent compilation of results from a number of studies (Stroul, 1993), outcomes from all such systems show a consistent pattern:

- Reduction in out-of-home placements;
- Reduction in out-of-county and out-of-state placements;
- Increase in stability of placements;
- Reduction in utilization of inpatient services;
- Reduction of length of stay in inpatient settings;
- Reduction in utilization of residential treatment center services;
- Reduction in length of stay in residential treatment centers;
- Increased use of less restrictive and more appropriate placements.

In addition to these reductions in more traditional and often more expensive care, these systems also demonstrate success in improving outcomes for these youngsters. Such systems show:

- Improved functioning on both specific behaviors and globally;

- Improved school attendance;
- Improved school performance;
- Improved school placement status;
- Reduced contacts with law enforcement;
- Reduced incarceration and recidivism rates for juvenile offenders;
- Increased parent participation and support; and
- Increased parent and youth satisfaction with services.

The newer approaches to provide comprehensive and flexible mental health coverage are now yielding cost analyses:

- In Fort Bragg, North Carolina, the average cost per client in a system of care is approximately \$5,380 as compared with \$10,992 at comparison sites (51% lower).
- In Kentucky, the Impact program is less costly to serve youngsters with an array of community-based services when compared with the previous, less comprehensive system. Under Impact, estimated costs were \$9.5 million compared with \$13.5 million for the prior year -- per child costs were reduced about \$4,300 (from \$19,539 to \$15,244).
- A state-wide approach in Vermont showed it was less costly to serve children in individualized services than in out-of-state residential placements. Average cost per child was \$57,218 for 10 youngsters in out-of-state placements for approximately 9 months, compared with \$43,025 for 19 youngsters in individualized services for at least 9 months (including education costs).
- In Ohio, costs for children receiving individualized services was 10% less (in a 6-month period) than previous costs with a traditional approach.

Overall, several systems have estimated costs that have been avoided by establishing comprehensive and flexible systems of care:

- Three comprehensive systems in California have saved over \$35 million in expenditures that would otherwise have been paid for group home residential care from 1989 to 1992. If all California counties had followed the same trend by utilizing systems of care, the state could have saved \$520 million in that period.
- In Ventura County, California, costs avoided by reducing youngsters' involvement in the child welfare, criminal justice or psychiatric hospital systems during 1985-1988 (period of the demonstration) were estimated at \$2,873,981.
- Family Mosaic, in California avoided costs by reducing the number of days of detention by 252 total days (\$50,178 for one year); and by reducing the number of days of psychiatric hospitalization (\$187,000 to \$102,000 for one year).

Clearly, community-based services have significant data from major controlled studies which demonstrate their effectiveness in improved outcomes for children, improved placement patterns with higher rates of services in less restrictive settings and in reducing costs. (Hoagwood, 1993).

Clinton's Health Security Act

The Health Security Act would provide access to a broad and extremely important array of services for children and adolescents with mental and emotional disorders. This range of services is similar to the range provided through the systems of care described above, and includes:

- Screening and assessment;
- Diagnosis;
- Day treatment and psychiatric rehabilitation;
- Behavioral aide services;
- Collateral services (for family members);
- Case management;
- Psychotherapy;
- Medical management;
- Family foster care;
- Group homes
- Crisis intervention;
- Crisis residential programs;
- Partial hospitalization;
- Residential treatment centers;
- Inpatient psychiatric hospital services.

However, the Plan imposes limits on these services: 120 days annually on intensive community services, 30 sessions per year of psychotherapy and 60 days annually, and 30 days per episode, limit on inpatient/residential care. Access is also restricted for certain services: additional days of psychotherapy may be covered, but only if the child would otherwise be hospitalized, the 30 day episode limit on residential treatment can be exceeded, but only if the child is found dangerous (a standard that is unlikely to apply to children). In addition, a complex set of trade-offs is provided, so that intensive community services can only be used if the family is willing to surrender inpatient/residential coverage, and use of the extended psychotherapy benefit also draws down on the inpatient/residential coverage.

The Health Security Act also proposes both continued authority for states to provide Medicaid services to eligible SSI and AFDC individuals, and authorizes a new federally-financed program for low-income children previously eligible for Medicaid. In a number of states, this could result in Medicaid-eligible children having access to the full range of services, without limits or trade-offs, since many states now include the components of a system of care for children under their Medicaid plans. While it is not yet clear whether this

language protects all currently eligible groups of children, we urge the Congress to retain provisions to protect Medicaid-eligible children from cutbacks in their benefits as the legislation moves forward. It is critically important, as we move to expand access to health care for all, not to undercut the current services made available in many states to low income children with serious emotional disturbance.

Conclusion

In health care reform, we have a unique opportunity to create a system which will assure that care is delivered both responsibly and appropriately, and commensurate with need. Indeed, the fully comprehensive, flexible benefit the President proposes in 2001 would accomplish that goal. Historically, the health insurance industry has fostered a system of care built around a specific payment structure and as a result, care is not always delivered based on need. We need to break this pattern and, as referenced above, models of delivery do exist to accomplish that and to provide service based on need.

The 18 organizations listed on this testimony, while applauding much of the President's plan, nonetheless urge the Committee to waive the limits on mental health services for children and adolescents now contained in the Health Security Act and delete the trade-off requirements with respect to child and adolescent services. This would grant our young people true security through access to the appropriate range of services as and when they need them. Anything less will condemn many youngsters to an ineffective level of care, to being removed from their families unnecessarily and it could set them on a path that leads to lifetime dependency on (or conflict with) society.

STATEMENT OF DIGESTIVE DISEASE NATIONAL COALITION

Mr. Chairman and members of the subcommittee, thank you for the opportunity to present the views of the Digestive Disease National Coalition (DDNC) on health care reform.

The DDNC is comprised of 23 national voluntary and professional organizations concerned with a broad range of digestive diseases, such as inflammatory bowel disease, a variety of cancers, ulcers, and other complicated, chronic diseases.

Mr. Chairman, the six principles of the plan outlined by the Clinton Administration to improve our nation's health care system are goals embraced by each of the organizations of our Coalition. Among those principles that are most central to individuals suffering from digestive disease is universal health insurance coverage that can never be taken away.

Twenty-two years ago my ulcerative colitis led to an ileostomy which has left me with an ostomy appliance attached to my abdomen to collect my body's waste. Even though I, unlike many patients with chronic digestive diseases, have not had a reoccurrence of inflammatory bowel disease for twenty-two years, I and hundreds of thousands of others suffering digestive problems have been discriminated against by health insurers because of our "preexisting conditions". Most people with severe digestive problems can not obtain health insurance because we are considered a bad risk, and undesirable by those offering medical benefits. Even after twenty-two years of average medical experience, I have the "privilege" of paying exorbitant fees for questionable health insurance coverage. The Administration proposing a system in which every American would be covered, and not be discriminated against, is a dream come true for countless citizens of this nation like me.

Mr. Chairman, there are some components of the health care reform proposal on which persons with digestive diseases would like to comment specifically.

Prevention Benefits and Colorectal Cancer Screening

Colorectal Cancer is the second leading cause of cancer death in the United States with 155,000 new cases each year. The death rate from a diagnosis of colorectal cancer approaches 60%. Colorectal cancer accounts for over half (1/2) of the 80,000 ostomy operations performed each year. Anyone can get colorectal cancer, as the members of the voluntary association I head can attest.

Despite these staggering statistics, colorectal cancer screening is not currently reimbursable for Medicare patients, and the Administration's reform proposal does not include coverage for periodic screening for colorectal cancer as a benefit in the preventive health benefits section.

The Digestive Disease National Coalition strongly urges your subcommittee to include coverage for periodic screening for colorectal cancer as a preventive benefit, and

reimbursable under Medicare in the package developed by Congress during its consideration of health care reform legislation.

Guidelines for screening adopted by the DDNC and the American Cancer Society are listed in a two page document that I will give you, and I hope you will agree to include in the hearing record. It is our sincere hope that your subcommittee will include coverage of benefits consistent with the agreed upon guidelines that are listed in this document. To do less would deprive those who run the risk of developing colorectal cancer the same opportunity to live a disease-free life as any other American.

Mr. Chairman, colon and rectal cancer is a serious disease that needs to be included in the preventive screening benefits portion of any standard health benefits package, and the Administration's proposal needs to be amended to address America's #2 cancer killer.

Access to Specialists

Many persons suffering digestive diseases have very complex or rare problems that require the attention of a qualified specialist or a team of qualified specialists. Many times, a person with a chronic digestive disorder searches for years for a specialist who can manage their complicated problems and offer the most comprehensive care available. Even among gastroenterologists, there are those that specialize in the management of patients with specific diseases. Freedom of choice must mean the right of the patient to select his or her own doctor, including both primary care physician and specialist.

The proposed health care system comes up short in two specific areas relating to the complex or unusual nature of digestive diseases. First, the restrictions associated with preferred provider organizations, HMOs and managed competition do not give a patient with a complicated, chronic digestive disease the freedom to find the right medical specialist to manage their disease. Instead, just the opposite is feared by those suffering digestive diseases. The cost differential for "out of plan" or "point of service" should not be so great as to preclude this option.

Our second concern, Mr. Chairman, is the proposed de-emphasis on the training of medical specialists. None of us would argue the need for a greater emphasis on primary care, but patients suffering complicated digestive diseases would agree that one should not be forsaken for the other. Patients suffering from digestive diseases are concerned that the proposed system would limit the number of qualified specialists to treat our complicated diseases, and that the de-emphasis on specialist training would lead to a virtual drying up of medical and scientific expertise in terms of developing more sophisticated diagnosis and treatment of severe digestive problems.

Ostomy Supplies & Home Care

The DDNC generally supports the proposed benefits outlined for ostomy supplies and home care services such as parenteral and enteral nutrition. We would recommend that patients be given a choice of suppliers and not be unduly constrained by sole source suppliers.

Clinical Research

In the managed care system, the ability to do clinical research needs to be preserved. This necessitates the ability of the hospitals to negotiate special reduced fees for examinations performed as part of research protocol.

Mr. Chairman, again, thank you for the opportunity to present our views.

STATEMENT OF NATIONAL ALLIANCE FOR THE MENTALLY ILL

Mr. Chairman, distinguished Members of the Subcommittee, thank you for the opportunity to submit our response to President Clinton's Health Security Act. I am Stella March, 1st Vice President of the Board of Directors of the National Alliance for the Mentally Ill (NAMI) and Chair of its Public Policy Committee. I have a son who has been suffering with schizophrenia for the past 19 years. He had his break during his second year as an honor student at UCLA.

NAMI is a self-help organization of families of persons of all ages with severe mental illness and of those persons themselves. NAMI's membership totals 140,000 families nationwide, including constituents in all of the Subcommittee Members' districts. Our organizational structure consists of a 15-member elected volunteer Board; a national office in Arlington, Virginia; 50 state offices; and nearly 1000 local affiliates.

NAMI families are deeply distressed and disappointed about the disappearing benefits under the Health Security Act -- benefits required to treat our sons and daughters, our siblings and spouses, and our aging parents who are suffering from neurological diseases of the brain -- schizophrenia, manic depression, clinical depression, obsessive/compulsive disorder and panic disorder. These diseases are as diagnosable as Alzheimer's and Parkinson's; as treatable as diabetes, heart disease cancer, and other physical diseases. Why the discrimination against our loved ones with severe diseases of the brain?

Could it be that they have been inappropriately placed under the mantle of "Mental Health" along with high profile functioning, working persons who have emotional problems of living, who respond to psychotherapy, (talk therapy), who are minimal users of hospital care and can afford co-payments. None of the above is applicable to persons with neurobiological diseases of the brain.

NAMI families want you to know that:

1. Our loved ones are on Supplemental Security Income and Medicaid, or Social Security Disability Insurance and on (or waiting for) Medicare. They may well be **WORSE OFF UNDER THE HEALTH SECURITY ACT AS IT NOW STANDS.** Yet

the President's coordinator of Health Reform, Mr. Magaziner, has stated often in public settings that the White House doesn't want any person dependent on public programs to have less in the reformed system than he or she has now.

2. Our loved ones are currently -- through a combination of new medications plus psychiatric rehabilitation and case management -- reaching their potential of recovery. They are able, for the first time in ten, fifteen, even twenty years - to resume their schooling, to apply for vocational training, to find part time paid jobs or volunteer work -- and to live in the community in the least restrictive environment. They are at risk of losing their ongoing rehabilitation and case management supports required to maintain their recovery -- under the arbitrary limits and cost-sharing requirements for these "intensive non-residential treatment" benefits in the Health Security Act.

3. Our loved ones, once they lack the appropriate ongoing care and support will return to the streets, to costly hospital care, to jails without care -- or to their graves. Not treating or under-treating persons with mental illness will be far more costly.

4. Yes, we are frightened about the future of our loved ones. And so are they. They will be denied full coverage -- they will be discriminated against until the year 2001. We cannot believe that President Clinton -- or this Subcommittee want to discriminate against our disabled family members suffering from neurobiological diseases of the brain. Persons with Alzheimer's, Parkinson's, or diabetes, etc. get their full benefits from the start. Why not persons with schizophrenia, manic depression, clinical depression?

NAMI families and consumers urge you to correct this injustice and discriminatory feature of the Health Security Act to insure a more secure future for these persons who have already lost large chunks of their life to these devastating diseases. They deserve no less.

Thank you.



National Association of State Alcohol and Drug Abuse Directors, Inc.

Introduction

NASADAD welcomes the opportunity to present testimony to Chairman Waxman and Members of the House Health and Environment Subcommittee. We are pleased that the Committee has chosen to focus attention on the mental health and alcohol and other drug benefit proposed by President Clinton and on other health care reform proposals.

NASADAD represents the concerns of State Alcohol and Drug Abuse Directors who manage nearly \$3.4 billion in public and not-for-profit programs that serve predominantly low-income individuals. Federal, State, and local dollars administered by State Authorities provide prevention as well as treatment services. Special programs and services are targeted to assist youth, pregnant and parenting women, and injection drug users. Programs are gender, culture, and age sensitive. State alcohol and other drug (AOD) programs also play a significant role in providing tuberculosis (TB), multiple-drug-resistant TB and HIV/AIDS services to alcohol and other drug clients who are at high risk for these diseases.

Comments on the *Health Security Act*

State Alcohol and Drug Agency Directors commend the Clinton Administration for its efforts to provide essential health coverage for Americans. The Clinton health care reforms, when enacted, will be a ground-breaking step toward achieving affordable quality health coverage for many Americans.

NASADAD also commends the Administration for recognizing that current benefits in the package will not meet the needs of many Americans for alcohol and other drug prevention and treatment services because of day and access limits. Coinsurance and co-payment rates will make it very difficult for low-income individuals to receive services under the current proposal. This recognition is demonstrated in the continuation of the public alcohol and other drug services program through the Substance Abuse Block Grant, the phasing in of more generous benefits in the year 2001, and the Administration's support for ancillary services such as outreach and transportation that are necessary to ensure access to services.

This testimony will address both the overall benefits of the *American Health Security Act* and some specific concerns about the level of alcohol and other drug services to low-income individuals. Comments will be limited to the alcohol and other drug portion of the benefit although many of the issues raised are also relevant to mental health services.

Essential Components of Health Care Reform

The proposed Clinton plan has many features that address weaknesses in the current system. NASADAD and its members recognize the significance of the following essential components of any health care reform proposal: /

- o Universal coverage is the goal and is largely achieved with the exception of coverage for prisoners and immigrants.
- o Americans will be assured that comprehensive health benefits will continue without interruption regardless of changes in health, employment, or economic status.
- o Substance abuse and mental health services are included as a part of the comprehensive benefit package. By the year 2001, a comprehensive mental health and substance abuse benefit is planned with appropriate management that replaces limits on services.
- o A public delivery system is maintained in the interim to assure services to individuals who are low income or in need of public assistance.
- o Alcohol and other drug collateral treatment is offered for family members.
- o Coverage for the cost of prescription medications is included.
- o Arbitrary caps on services are removed, and an individual may receive the services needed over his or her lifetime.
- o Penalties for pre-existing conditions are eliminated so that an individual who loses or changes jobs will not be penalized.
- o Continued funding is provided for the Ryan White Care Act so that essential services for individuals with HIV/AIDS is assured.
- o Employers are asked to contribute to the cost of the premium for full-time and part-time employees. Self-employed and unemployed persons and small businesses will be able to purchase less expensive insurance and will receive tax breaks or other support to enable them to participate.
- o States assume primary responsibility for establishing, regulating, and monitoring Health Alliances and providers as well as assuring that all eligible individuals have access to a health plan that delivers the guaranteed comprehensive benefit package.

Concerns About the *Health Security Act*

NASADAD is still seeking clarification from the Administration regarding interpretation of specific provisions of the benefit. The following comments do not reflect a full listing of concerns but only serve to highlight several main issues.

Unlike many other physical diseases, alcohol and other drug problems are often characterized by denial by both the patient and the family of the need for treatment. Relapses during treatment are often a part of the recovery process from alcohol and other drug problems.

It is important to consider how the alcohol and other drug benefit package can be structured to support the entry into and successful completion of treatment. The following concerns are raised about the substance abuse and mental health benefit in the *American Health Security Act*.

1. Substance Abuse Block Grant

One important question is the impact of a limited alcohol and other drug benefit on the public system. A recent NIMH study indicate that of persons 15 years and older: 18.3% have a mental health disorder and 11.3% have a substance abuse problem. (Of those with a substance abuse disorder, 9.7% have alcohol problems and 3.5% have drug problems.)

Because the AOD benefit is limited, access to services is complicated, and co-payments are required, few if any individuals eligible for the public system will be able to receive treatment under the benefit. In addition, many of the middle-income individuals who can utilize the benefit will seek treatment from the public system after they have exhausted the health plan benefit. Finally, individuals who are denied access to basic or additional treatment services may become the responsibility of public AOD treatment system. Thus funding for the Block Grant should be augmented and not decreased until such time as the benefit is significantly increased and day and access limitations are eliminated.

2. Co-Payments Are a Significant Barrier for Low-Income Individuals and Other Persons

The \$10 co-payment for services and \$5 co-payment for prescriptions present significant barriers to service for low-income individuals now receiving services through the public system. And, in contrast to other medical services, individuals receiving treatment for alcohol and other drug problems often require services on a daily or 4-times-a-week basis thus necessitating significant up front co-payments in a short period of time.

The benefit should be amended to reflect a sliding scale of payments of \$0 to \$10 so that no individual will be denied care because of an inability to pay the full \$10 co-payment. In addition, all co-payments, deductibles and co-insurance should count toward the out-of-pocket maximum as do other health services.

3. The Current Day Limits for All Categories of Services Are Inadequate

Day limits for hospital/residential, intensive nonresidential/partial hospitalization, and outpatient treatment are too restrictive and do not reflect good clinical practice. Alcohol and other drug problems are responsible for creating significant health care costs in other areas. (A recent study by the Center on Addiction and Substance Abuse at Columbia University showed that substance abuse is responsible for at least one in every five dollars spent by Medicaid on hospital costs.) For this reason, arbitrary limitations should be removed to assure that individuals receive the treatment that is needed and that will result in an overall reduction of health care costs.

4. Dually Diagnosed Individuals with Substance Abuse and Mental Health Problems Will Be Shortchanged

About 4.5% of individuals over age 15 have a combination of alcohol, drug and mental health problems. Different treatments are required for each problem. The *Health Security Act* should be amended so that individuals with a dually diagnosed problem are entitled to receive all levels of available service for both mental health and substance abuse problems.

NASADAD and its members are still reviewing the benefit and will have other questions and concerns to raise in the future. However, even allowing for weaknesses in the proposal, the *Health Security Act* still offers the best opportunity for meaningful progress for alcohol and other drug problems and for overall health care reform.

Thank you for allowing NASADAD to testify. We will be pleased to answer any additional questions at the request of the Committee. Please contact Bill Butynski, Executive Director or Kathleen Sheehan, Director of Public Policy at (202) 783-6868 for more information.

STATEMENT OF

NATIONAL COUNCIL ON ALCOHOLISM AND DRUG DEPENDENCE, INC.

The National Council on Alcoholism and Drug Dependence, the oldest and largest voluntary health agency in the field of addiction, thanks you for holding this hearing on President Clinton's proposed treatment benefit for alcoholism and drug dependence. Since 1944, NCADD has been a national leader in alcohol and other drug policy, education, prevention and treatment and is dedicated to supporting innovative approaches to advance the field. NCADD serves as an advocate for alcoholics, other drug dependent persons and their families and for the development of alcohol and other drug policies in the best interests of the public health. NCADD has strong links with community-based organizations through its 186 affiliates in 36 states.

NCADD supports the Health Security Act because it acknowledges that alcoholism and drug dependence treatment is an integral component of our health care system and includes a treatment benefit. We are also encouraged by President Clinton's commitment to provide universal coverage and to lift restrictions and limits on the benefit in 2001.

However, as advocates for the consumers of alcoholism and drug treatment services, we are alarmed by the inappropriate restrictions on the nature and duration of treatment services under President Clinton's proposal. We would like to make the following recommendations to Congress to improve the benefit:

- A comprehensive range of treatment services must be included in the basic benefit package. Lewin-VHI, Inc. has estimated that a comprehensive benefit would cost approximately \$45 per person per covered year. The benefit estimate by Lewin-VHI, Inc. would provide a full continuum of services, assume a 10% increase in utilization, a 50% increase in the funding per unit of service to improve the quality of care particularly in the publicly funded system and provide lengths of stay similar to the longer lengths of stay currently provided in the publicly funded sector with an additional 10% increase in response to improved quality.
- The Block Grant and other federal funding must be maintained at levels that will provide appropriate and adequate treatment to those who need it. States and local governments should not be allowed to reduce their funding commitments.
- Alcohol excise taxes must be increased to help raise revenue to fund a comprehensive benefit as well as reduce alcohol consumption. Reduced consumption will also lead to reduced alcohol-related health care problems.
- The alcoholism and drug dependence treatment benefit should be separated from the mental health benefit. These illnesses are different and have distinct health care systems.
- Utilization review and managed care standards must be the same

as those for other health care services. NCADD supports the implementation of the standards developed by the Legal Action Center.

- Cost-sharing requirements should be applied on the same basis as other prevention services. All out-of-pocket expenses that are incurred as a result of alcoholism and drug dependence treatment should be counted toward the yearly maximum.
- Community-based alcoholism and drug dependence treatment programs should be designated as essential providers.

Adequate and appropriate treatment for alcoholism and drug dependence are critical to the success of health care reform. Statistics bear out the problem:

- According to the National Institute on Alcohol Abuse and Alcoholism, in its Seventh Special Report to Congress, about 25% of all hospitalized patients have alcohol-related problems.
- The Center on Addiction and Substance Abuse, founded by Joseph Califano, former secretary of the Department of Health, Education and Welfare, has issued a report finding that at least 20% of Medicaid funds for hospital care and 20% of hospital days are attributable to substance abuse. That translates to \$4.2 billion of the \$21.6 billion spent on Medicaid in 1991.

- A study cited in the Journal of the American Medical Association in September 1993 concluded that the rate of alcohol-related hospitalizations among elderly persons is similar to hospitalizations related to heart problems. The costs to Medicare for this preventable problem are considerable. The report estimates that Medicare hospital costs related to alcohol were \$233.5 million in 1989.

- Over 32% of AIDS cases are linked to injecting drug use and over 70% of pediatrics AIDS cases are linked to maternal exposure to HIV through drug use or sex with a drug user. The Surgeon General's Report to the American Public on HIV Infection and AIDS states that the cost of providing treatment to people with HIV/AIDS ranges from \$85,000 to \$150,000 per patient.

If we do not address these problems now, we will continue to face massive health care costs, lost productivity and wasted human lives. We know that alcohol-related problems and drug abuse cost an estimated \$166 billion in 1991--\$99 billion of which is attributed to alcohol and \$67 billion of which is attributed to drug abuse.

Alcoholism and other drug addictions are chronic and relapsing conditions. A number of factors have made evaluation of the overall effectiveness of treatment very complicated. Long-term

treatment is necessary in some cases. Comparisons of treatment modalities are difficult because different drugs, combinations of drugs and populations are involved.

It is known, however, that alcoholism and other drug addictions are treatable conditions, and even incremental recovery benefits both the individual and society. Treatment helps reduce alcohol and other drug use and plays a critical role in reducing health care costs and in increasing productivity.

Recovery rates improve when each patient is matched to the most appropriate treatment, based on factors such as employment, health and psychological status, and whether there are dependents to consider (for example, a woman with children might do best in a program that includes child care services.)

A landmark study published by the New England Journal of Medicine in 1991 indicated that inpatient treatment coupled with Alcoholics Anonymous meetings may be more effective than less intensive alternatives. More than 200 people with an alcohol or other drug problem who had been identified through a corporate employee assistance program were randomly assigned to one of three rehabilitation methods: compulsory inpatient treatment (including attendance at Alcoholics Anonymous meetings), compulsory attendance at Alcoholics Anonymous meetings and a choice of options. The authors of the study compared job performance and abstinence rates for these individuals over a two-year period and discovered that

while individuals in all three groups showed improvement, the individuals who had been assigned to inpatient treatment (including attendance at Alcoholics Anonymous meetings) had the highest abstinence rates. These findings were especially apparent among individuals who had been using cocaine.

The Institute of Medicine reports that successfully treating alcohol problems costs ten times less than the economic toll they take on our society. The cost varies with the type of treatment and the severity of the problem. Over a six-month period, treatment of an individual ranges from \$1,000 to \$10,000. Over the same period of time, it costs \$20,000 to keep someone in jail for alcohol-and other drug-related criminal behavior according to the National Institute on Drug Abuse.

We know that treatment works. The National Council on Alcoholism and Drug Dependence strongly urges you to take this opportunity to improve the quality of and access to alcoholism and drug dependence treatment. It is vital that the estimated 5.5 million Americans, including 400,000 youths and 100,000 pregnant women, receive the treatment they need.

Thank you for your time and consideration.

Statement of Dr. Mitchell S. Rosenthal, M.D.
 President and Founder
 Phoenix House

For more than a quarter century I have been involved in the treatment of drug abuse, as president and founder of Phoenix House, the nation's largest non-profit drug abuse services agency. So, I am deeply concerned about the impact of the Health Security Act on drug abuse treatment. I am grateful to Chairman Waxman and the Subcommittee on Health and the Environment for convening a hearing specifically to focus on the mental health and substance abuse provisions of the Act.

While there is much to admire in the Administration's health care plan, and I am pleased, in many ways, to see substance abuse treatment within the basic health care delivery system, I find the Act's limitation of substance abuse benefits alarming. This is not to say that for some victims of substance abuse -- perhaps for many -- these benefits are not adequate. But they come nowhere near meeting the needs of heavy, high-risk drug users who make up the "hard core." I would, therefore, urge the Subcommittee to understand that this plan will not address the treatment needs of this population, and to convene a special hearing that separates this issue from the overall context of universal health care.

The Administration is not unaware of the attention hard core drug abuse merits. This population, which numbers well over a million, is specifically targeted for treatment by President Clinton's Interim Drug Abuse Strategy, which maintains that "reducing hard-core drug use is paramount to the resolution of this Nation's drug problem."

This is entirely appropriate as heavy, high-risk use has persisted in recent years, even as overall levels of drug use declined. The disordered behavior of hard core abusers now drives our most intractable social problems. It is largely responsible for homelessness, for terrifying levels of adolescent violence, and for the rising incidence of child neglect and abuse. Moreover, no population contributes more to escalating health care costs -- through the spread of AIDS and tuberculosis, the birth of drug-impaired infants, and repeated treatment for the wide range of disorders directly attributable to substance abuse.

The Health Security Act's limitation on benefits to support residential treatment -- just reduced in the Administration's draft bill from a maximum of 60 days a year to just 30 days -- flies in the face of the treatment priority the Interim Strategy gives to the hard core. For these men, women, and adolescents, the treatment of choice is comprehensive, residential and long-term. Such treatment goes well beyond arresting compulsive drug use. It must deal with the psychological basis of addiction, change attitudes and values that support drug abuse, develop alternative patterns, and provide new social and vocation skills. This magnitude of change is not accomplished easily or quickly

but rather requires an intensive residential regimen generally lasting at least 6-18 months.

Long-term, comprehensive, residential treatment, provided by non-profit, community-based agencies like Phoenix House are demonstrably more effective -- and significantly less expensive -- than short-term "chemical dependency" interventions that the Act would permit hospitals and free-standing proprietary clinics to provide. A full year of treatment in a community-based residential therapeutic community, with a broad array of educational, vocational and other rehabilitative services, costs less than \$20,000. Short-term inpatient care in a chemical dependency program can cost as much. And incarceration -- which is a likely fate for many untreated, disordered drug abusers -- costs substantially more and can last infinitely longer.

How are we to ensure the survival of these proven programs for the hard core? Not only do they fall outside the limits of present substance abuse benefits in the Health Security Act, but the very existence of the Act threatens the primary means by which the federal government presently supports these programs -- the ADM block grants. Already, consideration is being given to siphoning funds from the Substance Abuse Block Grant to cover costs of the Health Security Act's mental health and substance abuse benefits.

Logic argues that the last things we should now do is drain resources that support comprehensive, long-term, residential programs. We should, instead, seek means -- both within the new health care plan and outside it -- to strengthen these programs and expand our capacity to treat the more than a million disordered drug abusers we have in this country. Should we fail to do this, we will pay a fearsome price in crime, violence, and social disorder. And the dollar costs -- in criminal justice and corrections, in welfare, health care, and foster care -- will dwarf whatever is saved by limiting so severely, and so unreasonably, the substance abuse benefits of the Act.

I realize that you and your colleagues in the House of Representatives, in the Senate, and in the Administration face a nearly impossible task of attempting to allocate health benefits in ways that are equitable, economical, and compassionate. But the problems that would be created by failure to address properly the treatment needs of the disordered hard core are so great that they clearly merit special attention. I strongly urge this Subcommittee to turn its attention and considerable talents to this problem.

STATEMENT OF SOCIETY OF AMERICANS FOR RECOVERY

ADDICTION: AMERICA'S NUMBER-ONE PUBLIC HEALTH PROBLEM

The Society of Americans for Recovery — SOAR — thanks Chairman Waxman and members of the House Health and Environment Subcommittee for this opportunity to present testimony. The chemical dependency treatment benefits proposed by President Clinton and other health care reform proposals represent a significant step toward addressing the nation's number-one public health concern.

SOAR was established in 1990 by former Iowa Governor and Senator Harold E. Hughes, the author of the Hughes Act establishing the National Institutes of Alcoholism and Drug Abuse. SOAR represents an "invisible" but very real constituency: the millions of Americans whose lives have been directly affected by addiction, and who know that recovery is possible — that the addict is no longer a "hopeless case." Most people never see the results of treated addiction: the 20 million people, addicts and their families, who today are in recovery.

Any effective effort to stem the epidemic of addiction must be based on the insight of those who have survived addiction — the people who know first-hand what works. They can testify that treatment works, and that recovery from addiction disease must become a national priority.

By current estimates, more than 24 million Americans still suffer from this devastating disease; 85 percent of these people will not receive treatment. And these numbers do not account for the future generations who will inherit the predisposition to addiction. Treatment now is available only to the well-to-do and some of the very poor. Publicly funded treatment programs usually have long waiting lists. Especially during the crucial early months or years of chemical dependency, working Americans and their families do not have adequate access to sustained treatment and prevention services.

Treatment is an Economic Recovery Tool.

A comprehensive addiction treatment benefit makes sense economically as well as ethically. The costs to American society of untreated addiction — auto accidents, child and spouse abuse, emergency room visits, lost job productivity, crime — now total about \$300 BILLION annually. Without policy changes this amount will grow to \$1.8 TRILLION by the year 2000. In addition, the estimated cost of treating the nation's 250,000 fetal alcohol victims is \$1.4 billion. The projected health care costs for all other drug-affected infants will reach \$2.5 billion by 1997. Meanwhile, more than 100,000 "crack babies" are born each year.

Moreover, significant reduction in America's health care costs is unlikely if we do not face our addiction problem. The economic incentives for early, effective, and continuing treatment for alcoholics and other drug addicts should be clear to every provider who has had to finance the consequences of continuing addiction. National economic recovery will be virtually impossible unless these costs are addressed.

A rational treatment policy for addicts and alcoholics will reduce health care costs, restore family unity, and increase productivity. The addiction disease benefits now included in the Clinton health security plan are cost-effective — for the health system, for individuals, and for the nation. People in recovery from addiction incur health care costs lower than the average for their respective age groups. Individuals who continue in their addiction experience very expensive deterioration and death — most often paid for by taxpayers. A recent University of California study has concluded that every \$1 spent on treatment saves society \$11.54.

Our nation's drug use problems cannot be solved until all Americans own their stake in the problem and participate in the solution. Education, prevention, early detection, intervention, and effective treatment all are hindered by continuing stigma, discrimination, misinformation, and denial. America needs leadership to place this national killer on the same public policy footing as diabetes, cancer, multiple sclerosis, polio, and other public health menaces.

Thank you for allowing SOAR to testify. We will be pleased to answer any additional questions at the request of the Committee. Please contact Senator Harold E. Hughes (Ret.), chair and CEO, or Johnny W. Allem, Executive Director for Development and Communications, at (202) 347-4257 for more information.

STATEMENT OF SUDDEN INFANT DEATH SYNDROME ALLIANCE

Mr. Chairman and members of the subcommittee, thank you for the opportunity to present the views of the Sudden Infant Death Syndrome Alliance regarding the Administration's proposal to reform the nation's health care system.

The SIDS Alliance is an organization comprised of thousands of individuals and families around the country that have been devastated by the sudden unexplained loss of an otherwise healthy baby.

Sudden Infant Death Syndrome is a frightening disorder that knows no economic boundaries; it can strike an infant from any country, culture, or socio-economic status. In the typical, but horrible SIDS case, an apparently healthy infant is put to bed for the night or for a nap without any indication that something is wrong. Sometime later, the infant is found lifeless. The infant's prior medical history, a complete postmortem examination, and a thorough investigation of the death scene provides no explanation for the cause of death. SIDS leaves in its wake grieving families and frustrated health care professionals.

Mr. Chairman, each year 7,000 infants die as a result of SIDS -- one baby each and every hour of each and every day -- including holidays. SIDS is the number one killer of babies two weeks to one year old, and is a major factor contributing to the high rate of infant mortality in the United States.

SIDS & The Health Security Act

Families affected by Sudden Infant Death Syndrome vigorously applaud the Administration's initiative in health care reform. Never before has such a comprehensive review of our nation's system been done. The simple recognition that our health care system does not work for many people in this nation is a significant one. That the President has placed health care reform high on the list of national priorities is commendable.

Maternal & Child Health & SIDS

Even though very little is known about the cause or causes of SIDS, the Health Reform proposal's emphasis on guaranteed access and improved prenatal and well baby care bodes well for improved attention to infants during their first year of life. Additionally, it is known that babies born prematurely, below normal weight, and whose mothers smoke during pregnancy are at greater risk of SIDS. While there are no known standard set of predisposing factors leading to a SIDS episode, perhaps the greater attention to the health and well being of each and every infant could lead to a greater understanding of those factors that precede the unexplained death of an infant. More attention on infant health and infant mortality may provide some answers to why apparently healthy babies die of Sudden Infant Death Syndrome.

Prevention & SIDS

The foremost agonizing thought on the mind of each SIDS parent is "What could I have done to prevent this from happening to my baby?" For too long, the nation's system of health care has focused on episodic sickness, rather than preventing illness - or even death. The SIDS Alliance has reviewed the prevention initiatives in the President's plan and believes that in many respects, the proposal represents some attention to prevention screening activities and research. However, we do not believe the plan allocates enough resources. We also question the flexibility of the prevention initiatives with respect to the ability of health care professionals to respond to the challenges and opportunities that exist in preventing disease. We believe that much more effort needs to be placed on prevention activities.

Once a SIDS episode occurs, there is no medical procedure, operation, or drug, that can be administered to bring a SIDS baby back to life. The only way to stop SIDS is to understand it -- and prevent it from happening.

Federal SIDS Initiatives

Mr. Chairman, there are three major federal initiatives occurring currently that address Sudden Infant Death Syndrome. How we view health care reform can be gauged by how these major initiatives are impacted by the various proposals.

- 1.) **The SIDS 5 Year Research Plan** - The National Institute on Child Health & Human Development is the major agency conducting SIDS research through the 5 Year Research Plan. The SIDS Alliance recommends that the prevention initiative in the health care reform proposal be flexible enough, and funded adequately to support a dramatic acceleration of research into preventing Sudden Infant Death Syndrome. Preventing SIDS and reducing infant mortality must be major priorities in health care reform.
- 2.) **Death Scene Protocol** - 50 different states in this country have at least 50 different ways of conducting the investigation at the scene of an unexplained infant death. SIDS parents living the real nightmare of the death of their baby have also had the unfortunate experience of spending that same night in jail, as a result of a lack of standard protocol for what should occur at the scene of an unexplained infant death. Later this year the Centers for Disease Control and the National Institutes of Health, will issue a recommended Standard Death Scene Protocol to states in hopes that they will be adopted on a state by state basis. The standard protocol will be more sensitive to grieving parents and attempt to collect the best information to be used in gaining further understanding about SIDS.

- 3.) **SIDS Services** - Each of the 7,000 SIDS deaths annually leave 7,000 sets of parents, siblings, grandparents, and friends desperate for answers and in need of professional support, counseling, and bereavement services. Mr. Chairman, until we can prevent SIDS, more discretionary resources must be dedicated to SIDS services. There should be more emphasis on helping a family struggle through this crises that might leave the SIDS victim's 3 year old sister wondering, "Will I die tonight ?" Instead, SIDS service programs around the country have been virtually wiped out with the advent of block grants. The Health Reform proposal does focus more funding on public health crisis, and prevention, but maternal and child health services, such as SIDS services come up short. The availability of these support services are essential to families who have lost a child to SIDS.

Thank you for the opportunity to present the views of the SIDS Alliance. I would be happy to answer any questions that you may have at this time.

HEALTH CARE REFORM

Health Plans, Risk Adjustment, and Corporate Alliances

THURSDAY, DECEMBER 9, 1993

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:50 a.m., in room 2123, Rayburn House Office Building, Hon. Henry A. Waxman (chairman) presiding.

Mr. WAXMAN. The meeting of the subcommittee will come to order.

In previous hearings, the subcommittee has looked at the basic structure of the President's health care reform proposal, including the roles of regional health alliances, of States and of the National Health Board, in assuring universal coverage and containing health care costs.

Today's hearing will look at three additional elements of the President's health care reform proposal: (1) the terms on which health plans can operate within regional alliances; (2) provisions for risk adjustment of premiums paid to health plans; and (3) the terms on which large employers, Taft-Hartley plans and other entities can operate as corporate alliances.

A central objective of the President's proposal is to give all Americans an annual choice among competing health plans. For those covered through regional alliances, their choices will, at a minimum, include a fee-for-service plan. For those covered through corporate alliances, their choices must include a fee-for-service plan and at least two plans that are not fee-for-service plans. For many Americans, this will represent far more choice than they currently have.

Not everyone will be covered through a regional alliance. The President's plan gives large employers—those with 5,000 or more employees—as well as certain Taft-Hartley plans and rural co-operatives the option to remain out of the regional health alliances and instead to operate a corporate alliance. In general, Americans who work for employers operating or participating in corporate alliances will select among health plans offered by their employer's corporate alliance.

The choice by individuals from among competing health plans is a critical element of the President's cost containment strategy. Because plans will be prohibited from refusing to enroll people or

charging them higher premiums based on their health status and from denying coverage for preexisting conditions, plans will, in theory at least, compete for enrollees on the basis of price, quality, and service.

In order for this cost containment strategy to work, the current incentive for plans to compete by avoiding high-risk enrollees must be eliminated. To accomplish this, the President proposes that the premiums paid to the plans by regional alliances be risk-adjusted—that is, the plans should get higher or lower premium payments depending on whether their enrollees have above or below average health risks. This requirement does not apply to payments made to health plans by corporate alliances, because the premiums that the corporate alliances pay to plans will be experience rated.

As we will hear today, there is considerable dispute as to whether currently available methodologies for risk adjustment are adequate to this task. If they are not, we need to explore what additional steps can be taken to prevent plans from profiting by avoiding people in poor health.

Before calling on our witnesses, I would like to recognize the distinguished ranking minority member of the subcommittee, Mr. Bliley, for the opening statement.

Mr. BLILEY. Thank you, Mr. Chairman.

Mr. Chairman, I read in the newspaper today that a private research group has performed a study of the President's plan which basically finds the financing of the plan sound. Well. Well. Well. I guess we might have as well have the vote right now.

But wait a minute. Towards the end of the article there is a little blurb that notes that this study is based on all of the plan's assumptions coming true. So, I guess if the Clintons said that filet mignon would cost 5 cents a pound we could all eat like a king for under \$1 a day, if we accept all of the assumptions at face value.

I see Mrs. Feder here again, and I am reminded of that commercial that we saw a lot of in 1984, "Where is the beef?" We have been waiting since September the 28th for the underlying assumptions which the First Lady so graciously promised to send me and we are still waiting. How can we make conclusions if we can't see the underlying analysis?

Mr. Chairman, I have got a long statement. I know you are dying to hear it, but for the sake of time and brevity, I ask unanimous consent to include it in the record.

Mr. WAXMAN. Without objection, that will be the order.

[The opening statement and charts of Mr. Bliley follow:]

OPENING STATEMENT OF HON. THOMAS J. BLILEY, JR.

Mr. Chairman, in today's newspapers we are told that a research group, Lewin-VHI has performed a study on the President's plan which basically finds the financing of the plan sound. I am sure in the next month or two numerous other private consulting firms will release conflicting reports on the Clinton plan. Let us remember that all of these private sector firms are "hired guns". For some peculiar reason, studies produced by such firms always provide conclusive proof for the sponsor's position on the issue.

Since we currently do not have page one of substantive analysis from the administration on how they calculated their numbers, I would again like to point out the flaws in the Clinton financing scheme. Today's Washington Post article identifies me

and Chairman Waxman, among many others, as some of the critics of the administration's financing plan. I would again like to strongly affirm my belief that the President's health plan will result in massive underfunding and the need for new taxes and premiums.

I would again like to point out that the cost containment features of the Clinton plan are also its primary financing mechanism. If any of the major cost containment features of this plan were changed, or more importantly, if any of the estimates of entitlement savings prove inaccurate, the overall financing of the health care plan would fall apart like a "house of cards." Why? Because, it is the CPI premium cap and the draconian Medicare and Medicaid cuts which are supplying over two-thirds of the plan's financing. If the entitlement and other cuts do not materialize, the Federal budget deficit will explode like a super-nova. If the Congressional Budget Office [CBO] and HCFA estimates prove to be wrong, and based on past experience that is a certainty, hundreds of billions of dollars will be added either to the budget deficit, or the tax burden on the American public.

With regard to the premium cap, let me quote from Dr. Stuart Altman's written testimony: "It should be understood, Mr. Chairman, that a CPI target would create a tighter spending control system than of any other nation." This is a point I first addressed to Mrs. Clinton at our hearing on September 28th, when I used this chart comparing international growth rates. I pointed out to her that in the 1985-1991 time period, the British Nationalized Health Care System grew at an annualized, per capita rate of 3.84 percent above inflation, and the Canadian single-payer system grew at an annualized, per capita rate of 3.58 percent above inflation. My question to Mrs. Clinton was simply this: No nationalized system has come even close in limiting spending to the CPI, and in the case of Britain and Canada, we are talking about systems that explicitly ration care. How is the administration's plan going to accomplish this extraordinary reductions in health care spending, when even systems that ration, have not remotely approached these spending limits?

Since that first hearing I have asked Secretary Shalala and other administration officials the same question. At this point, I have not received a satisfactory answer. The fullest answer was given by Mrs. Clinton. She said that Dr. C. Everett Koop had told her that there were \$200 billion of wasteful and unnecessary costs in the U.S. health care system. \$200 billion would represent approximately 20 percent of all national health care expenditures. When Secretary Shalala testified before us, I asked her to document some of the \$200 billion of unnecessary costs in the system. She was able to document only a small fraction—\$1.5 million to be exact! Maybe Dr. Feder can use her oral testimony today to document the \$200 billion figure, and more importantly, show us how we are going to become the slowest growing health care system in the western world without rationing health care.

Finally, lets look more closely at the plan's financing. For the time period of 1995 through the year 2000, Medicare and Medicaid are cut approximately \$200 billion. During the same period, the health care programs of the Veterans, the Department of Defense, and Federal employees are cut approximately \$40 billion. These cuts represent roughly 60 percent of the new financing in the Clinton plan. These cuts are then used to buy new benefits or provide subsidies to small businesses and low-income individuals. Therefore, the "savings" from the entitlement cuts are already spent. The critical question is—will the entitlement savings ever materialize?

History is the best guide. Lets look at this chart which compares the CBO Medicaid and Medicare baselines in January, 1991 and January, 1993. The top line is the January, 1991 CBO Medicaid baseline calculated on the statutory changes made in the 1990 Reconciliation bill. CBO initially estimated that total Medicaid spending for the years 1992-1996 would be \$363 billion over 5 years. During their January, 1993 re-estimate the equivalent baseline had grown to \$463 billion, a \$100 billion increase. An identical analysis of the Medicare baseline shows a \$51 billion increase over 5 years. Therefore, we can say that the initial Medicaid/Medicare estimate of the 1990 Reconciliation bill was off by a staggering \$151 billion over 5 years.

Now let's look briefly at CBO's ability to estimate the cost of new benefits. Lets look at what occurred during the short life span of the Medicare Catastrophic Coverage Act (MCCA). When the Act passed Congress, the official CBO estimate for the new benefits was \$30 billion over 5 years. One year later, CBO re-estimated the cost of the benefits at \$48.3 billion, a whopping \$18.2 billion increase in less than a year. And let me remind my colleagues that some of the major benefits had not even been phased-in yet.

These two examples are representative of many others and point to two principles of Federal budgeting: (1) CBO tends to grossly under-estimate the cost of new benefits; and (2) tends to dramatically over-estimate the "savings" that can be "squeezed" from the health care entitlements. If we apply these principles to the Clinton plan, we can begin to understand that the plan may not only irreparably damage the world's greatest health care system, but could also simultaneously send the Federal budget into a "black hole."

Let me again reiterate, that Congress will not base its legislative deliberations on analyses performed by "beltway bandits" or other "hired guns."

Average Annual Growth in Per Capita Health Expenditures
(Adjusted for Inflation 1985-1991*)

<u>Country</u>	<u>% Increase (1985-1991*)</u>
Turkey	9.61
Spain	6.69
Italy	5.55
Finland	4.97
Iceland	4.48
Luxembourg	4.41
Norway	4.30
Japan	4.24
Belgium	3.95
United Kingdom	3.84
Canada	3.58
Portugal	3.41
France	3.26
Austria	3.05
Netherlands	2.94
Ireland	2.67
Greece	2.26
Australia	2.08
New Zealand	2.06
Germany	2.05
Denmark	2.03
Switzerland	1.82
Sweden	0.48

United States 0**

* Numbers are the percentage by which the increase exceeds the rate of inflation, as measured by the GDP inflator.

** Number from §6001(3)(A), p. 986, H.R. 3600.

Sources: Organization for Economic Cooperation and Development, 1985-1991 comparison; H.R. 3600 as introduced.

CBO Baseline Projections For Medicare & Medicaid

(by fiscal year in \$billions)

Medicaid

	1992	1993	1994	1995	1996	Totals
Jan. 1991*	\$57	\$64	\$72	\$80	\$90	\$363 billion
Jan. 1993**	\$68	\$80	\$92	\$105	\$118	\$463 billion

Difference,

1993-1991	+11	+16	+20	+25	+28	\$100 billion
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\$100 billion added to Medicaid CBO baseline between Jan. 1991 & Jan. 1993 Budget Outlooks due to "technical corrections." Technical adjustments not subject to PAYGO requirements.

Medicare

	1992	1993	1994	1995	1996	Totals
Jan. 1991*	\$127	\$140	\$156	\$173	\$194	\$790 billion
Jan. 1993**	\$129	\$146	\$167	\$188	\$211	\$841 billion

Difference,

1993-1991	+2	+6	+11	+15	+17	\$51 billion
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\$51 billion added to Medicare CBO baseline between Jan. 1991 & Jan. 1993 Budget Outlooks due to "technical corrections." Technical adjustments not subject to PAYGO requirements.

* *The Economic and Budget Outlook: Fiscal Years 1992-1996, January 1991, Congressional Budget Office, p. 91*

** *The Economic and Budget Outlook: Fiscal Years 1994-1998, January 1993, Congressional Budget Office, p. 49*

Medicare Catastrophic Coverage Act, and its Repeal

	<i>Outlays 1989-1993</i>		<i>Difference</i>	
	<i>June 1988 Estimate*</i>	<i>August 1989 Estimate**</i>	<i>\$</i>	<i>%</i>
<i>Prescription Drugs</i>	\$5.70	\$11.80	\$6.1 billion	207%
<i>Skilled Nursing Facilities</i>	2.10	13.50	\$11.4 billion	643%
<i>HI (Non-SMF)</i>	7.40	7.80		
<i>SMI (Part B)</i>	14.90	15.20		
Total	30.10	48.30	\$18.2 billion	

All amounts in \$billions.

*Official CBO cost estimate when Medicare Catastrophic Coverage Act (MCCA) enacted

**Aug. 1989 CBO memo on reestimating MCCA prepared for Senate Finance Committee

Mr. WAXMAN. Mr. McMillan?

Mr. MCMILLAN. Thank you, Mr. Chairman. I have a brief statement but I won't even use that.

I would like to welcome you back and really underscore what the ranking member, Mr. Bliley, said. I think you probably agree with us that there is something holding us back. How do experts such as those at Lewin get hold of information that apparently we can't get hold of? Or maybe when we read the report, what has been said will be found to be true. That they really assumed—accepted information provided by management and didn't question it. But I hope we will have an opportunity to find that out.

Could I ask the question one more time, when do you think we will receive—

Mr. WAXMAN. Well, would the gentleman just make the opening statement? Then we will get to questions after the testimony.

Mr. MCMILLAN. All right.

I will simply put you on notice that I will ask that question when the opportunity arises.

And I yield back the balance of my time. Thank you.

Mr. WAXMAN. Thank you, Mr. McMillan.

Mr. Hastert?

Mr. HASTERT. Thank you, Mr. Chairman. Just a short opening statement.

I would like to join the chorus here today. I appreciate you being here today and look forward to your testimony.

And again, I recognize you, Dr. Feder, as being one of the architects of this plan. I appreciate the discussions we had early last spring with you and Ira Magaziner. We talked about parameters and how we could work on health care on a bipartisan basis, and at that time I think there was genuine interest to do that.

Early on, from you and then again from Ira Magaziner, there were promises that the administration would be able to share the underlying studies, the underlying economic assumptions and analysis on which this program was built. We have this whole scenario of hearings, but without facts, without numbers, without the basic underlying tenets of how this thing was put together, it is like trying to engineer a building without the blueprints, and that is our job to do that. We are very, very frustrated on this side of the panel.

We are sitting here, in a sense, with you holding all the cards, all the information, and us just trying to guess where these ideas are coming from, where the numbers are coming from, where the economic ramifications are coming from, and I just want you to understand our frustration.

And with that I will close, but again look forward to your testimony today and your ongoing cooperation.

Mr. WAXMAN. Thank you, Mr. Hastert.

Mr. Brown? Do you have a statement?

Mr. Moorhead?

Mr. MOORHEAD. Mr. Chairman, I wish to join the others in welcoming Judith Feder this morning to the panel.

I want to echo what has been said before. The major concern Republicans have had with this legislation is that we have asked witness after witness to give us the background materials and they

have all promised to do so. Yet months and months go by and none of it is offered. And yet we are coming to the point very shortly, following the recess, when we will be marking this legislation up. It is impossible for us to do all that has to be done after we get that material if we don't get it almost immediately.

I know everyone wants cooperation, but it has to be a two-way street, and it hasn't been forthcoming so far.

So, we are looking forward to your testimony today.

Mr. WAXMAN. Thank you, Mr. Moorhead.

Our first witness today is Judith Feder, the Principal Deputy Assistant Secretary for Planning and Evaluation. She is accompanied by Gary Claxton, a Senior Analyst at the Department of Health and Human Services.

On November 2, Dr. Feder testified before our subcommittee on the structure of the President's plan focusing on regional health alliances. Yesterday, she described the President's proposed benefits package. Today, we have asked her to review the bill's provisions relating to health plans, risk adjustments and corporate alliances.

Dr. Feder, welcome back. We missed you. It seems like so long since we last saw you.

Without objection, your written statement will be included in the record in its entirety. We would like to ask you, if you would, to limit the oral presentation to 5 minutes, so we will have an ample time for questions and answers.

STATEMENT OF JUDITH E. FEDER, PRINCIPAL DEPUTY ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY GARY CLAXTON, SENIOR ANALYST

Ms. FEDER. Thank you, Mr. Chairman. And it is, Mr. Chairman, Mr. Bileley, members, it is a pleasure to be here again. And with regard to the opening statements, may I say that it is my strong and profound wish that I not appear before you again until I have got those numbers for you, and we are doing our utmost to have them to you as quickly as possible and I hope in the very immediate future.

As you indicated in your opening statement, you have asked me to come today to talk about the way in which the Clinton health plan will assure universal coverage to comprehensive benefits through a competitive health care marketplace and to address specific aspects of that marketplace, the nature of health plans and risk adjustments as needed to assure their appropriateness and viability in terms of handling the patients they serve, and to discuss corporate alliances, and so I will proceed first with the plans and then with the corporate alliances.

Health plans will operate within a Federal framework. That framework provides for universal coverage and a guaranteed package of comprehensive benefits, insurance reform, including guaranteed acceptance and renewable coverage and community rating; access to fee-for-service coverage; administrative simplification, including uniform reporting requirements and standard claims forms; choice of health plans by informed consumers; a national quality management program that includes core quality and performance measures for health plans and for health care providers.

As a result of these Federal guarantees, health plans will for the very first time compete head to head for enrollees. With the same benefits in each plan and the comparative performance report information available from alliances, consumers will be able to meaningfully compare plan quality and costs and choose the type of plan providers and premium structure which best meets their needs.

States will be responsible for oversight of health plan operation. In particular, States will be responsible for certification of health plans, regulating health plan solvency, and establishing an administrative appeals office for complaints that might arise against health plans.

Health plans will be responsible for delivering the comprehensive benefits within the premium they bid and consistent with the target established by the National Health Board for each regional and corporate alliance.

Alliances will negotiate with health plans over premiums, and we believe that health plans will be—the competition will induce plans to offer high quality service at affordable prices in order to attract and retain enrollment.

However, if the average premium in an alliance should exceed the target for that alliance, the Act contains provisions to reduce plan premiums and spending to targeted levels.

To address concerns about risk selection in the marketplace, the Health Security Act contains a series of integrated steps, including, first, assuring universal coverage and a standard package which reduces adverse selection by people facing higher risks, enrollment through health alliances which eliminates the capacity of health plans to selectively market in order to avoid risks, marketing reforms, insurance underwriting and rating reforms that eliminate rate discrimination against higher risk people, reforms and plan contracting rules, including provisions that require all health plans to contract with academic health centers in order to provide appropriate services to people who have greater health problems, mandatory reinsurance of high-cost cases and conditions, and adjustment of health plan premiums for demographic and health status variations through prospective adjustments to the payments made to health plans.

This set of requirements, Mr. Chairman, we believe will assure that health plans are paid appropriately for the population that they serve and will have very little, if any, opportunity to selectively enroll or disenroll particular populations.

Turning to the corporate alliances, the Health Security Act permits employers of sufficient size along with Taft-Hartley plans and rural electric cooperatives to continue to have the option of self-insuring their employees' health benefits by forming a corporate alliance. Any private employer with over 5,000 full-time employees nationwide may elect to form a corporate alliance. These large employers may also choose, if they wish, to participate in a regional alliance.

A corporate alliance will serve the same functions as a regional alliance under similar requirements, and ERISA will be amended to ensure that that happens. Corporate alliances must offer health plans that provide the nationally guaranteed comprehensive benefits. Each corporate alliance must hold an annual open enrollment

and provide comparative information about health plans for their employees.

Grievance procedures and reporting requirements applicable to regional alliances also apply to corporate alliances, as do the changes we have made for administrative simplification.

Each corporate alliance must offer at least one fee-for-service plan and at least two other plans. Corporate alliance plans must accept all eligible enrollees on a first come-first serve basis and may not terminate enrollees or limit coverage for the nationally guaranteed comprehensive benefit package.

Exclusions for preexisting conditions and waiting periods are prohibited. Plan premiums in the corporate alliances, as in the regional alliances, must stay within the nationally established premium cap.

Employers that form a corporate alliance will periodically have the opportunity to move into the health alliance if they choose. Once in the regional alliance, there is no opportunity to return to corporate alliance status. The concern being that we do not want a gaming and risk selection with respect to the regional alliance enrollment.

For corporate alliance-eligible employers who choose to join the regional alliances, community rating and discounts will be phased in over an 8-year period regardless of when they join. Again, the concern is to prevent any kind of gaming or risk selection.

Mr. Chairman, this concludes my opening remarks with respect to the issues that you have asked me to address this morning, and I look forward to addressing any and all questions you have for us.

Mr. WAXMAN. Thank you very much for that presentation, and, of course, that longer statement will be in the record.

[The prepared statement of Ms. Feder follows:]

STATEMENT OF
JUDITH E. FEDER, Ph.D.
PRINCIPAL DEPUTY ASSISTANT SECRETARY
FOR PLANNING AND EVALUATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. Chairman and Members of the Subcommittee:

Today, our health insurance and health care delivery systems suffer from major flaws that threaten our health security. The President's Health Security Act addresses these flaws, by attacking the causes of the problem. For example:

- Universal coverage will provide security for all, regardless of employment or economic status.
- Our insurance reforms will prevent health plans from pricing the sick out of the market, and will force health plans to compete to provide care to those who need it most.
- Through marketplace competition and state oversight, health plans will be held accountable for the quality and cost of the care they provide.
- Collection and dissemination of practice information and the development of quality standards will assist health care practitioners in developing effective treatment protocols.

In the rest of my testimony today, I will describe the role of health plans in accomplishing these goals, the role of the States in overseeing health plans, and the role of corporate alliances.

HEALTH PLANS

Health plans will provide health insurance coverage, much as insurance companies and HMOs provide such coverage today. A health plan can be a fee-for-service plan like today's indemnity plans, an HMO, a PPO or other type of network, or any other arrangement that meets the federal and State requirements. There must be at least one fee-for-service plan available in each alliance. Every person will choose his or her own health plan and physician.

Health plans (other than fee-for-service plans) will have flexibility in structuring their relationships with providers. Providers themselves will be encouraged to form new health plans. Health plans will be required to contract with Essential Community Providers during a transition period and pay them no less than rates paid to other providers in the community, or pay them based on Medicare reimbursement principles.

The Federal Framework for Health Plan Operations

Health plans will operate within the following federally mandated parameters:

Universal coverage. All U.S. citizens and legal residents will be covered.

Guaranteed comprehensive benefits. Each health plan must offer the nationally guaranteed benefits package, which will be updates over time to reflect changes in health care practices and technology. Health plans may offer supplemental policies.

Insurance reform. All plans must accept applicants on a first come-first served basis (unless the plan is a closed panel plan which is full); risk selection is prohibited. Community rating is required.

Fee-For-Service Option. All health plans that rely on a network of participating providers must also offer an "out-of-network" option, enabling enrollees to seek care from nonparticipating providers. The option can be offered as part of the plan arrangement or as a separate option.

Standardized forms and administrative simplification. Uniform reporting requirements and standardized forms will dramatically lighten health plans' paperwork burden.

Consumer protections. Each health plan must provide to the alliance information concerning its costs, the qualifications of its providers, its utilization management and quality assurance procedures, and its consumer grievance procedures. The alliance will make this information available to consumers in a standardized format, to facilitate comparison. Consumers will be guaranteed grievance and appeals procedures that meet Federal requirements.

Quality Standards. The National Board also will develop the core quality and performance measures for a health plan performance report, so that quality can be easily compared and evaluated and improved across the country.

As a result of these federal reforms, health plans will -- for the first time -- compete head-to-head for enrollees. With standard benefits and the comparative performance report information available from their alliances, consumers can meaningfully compare plan quality and costs, and choose the type of plan, providers and premium structure which best meet their needs. These competitive pressures will create new incentives for health plans to develop innovative approaches to management of acute and chronic conditions.

Competition will be further enhanced by expanding the number and type of coverage options available to consumers. Today, many people must choose from the one or two plans offered by their employer. The President's plan will dramatically increase consumer choice, by making all certified health plans operating in a community available to everyone in that community, through the regional alliance.

State Oversight of Health Plans

States are responsible for oversight of health plan operations. In particular, the Act assigns to states responsibility for certification of health plans, for establishing solvency standards (consistent with federal minimum standards) and ensuring that these standards are met, and for establishing an administrative appeals office for complaints against health plans.

Certification. Only health plans that have been certified by the State as meeting Federal and State requirements can obtain enrollees through an alliance. Certification standards include compliance with the federal insurance reforms, as well as with state-established standards.

Quality. Quality oversight is the responsibility of each State -- health plan quality is one of the core criteria for state certification of health plans. States will have broad flexibility in how they measure and evaluate plan quality. Today there are as many different performance tools as there are health plans. Under the Health Security Act the quality measures developed by the National Board (described above) will be available to States to evaluate quality performance.

Solvency. States have the primary responsibility for assuring the financial solvency of health plans. States must certify the financial stability of each plan, and each plan's capacity to deliver the comprehensive benefits package. States establish capital standards (consistent with federal minimum standards), reporting and auditing requirements, and reserve requirements for health plans. States must monitor health plans, to assure that they continue to meet certification requirements. States may require Plans to purchase reinsurance.

Protections in the Event of Plan Failure. States, as they do today, will designate an agency of state government to supervise (or take control of) plan operation in the event of plan failure. States must also amend this guarantee fund law to meet federal requirements, to protect providers and others in the case of plan failure. If a health plan fails, the State is authorized to impose a surcharge on other health plans to cover claims against the failed plan.

Appeals. Each State must establish a Complaint Review Office, to handle appeals from regional alliance and corporate alliance health plan actions. The procedural rules governing these state administrative appeals will be established by the Department of Labor. For appeals from Regional Alliance health plans, the Complaint Review Office will offer claimants the option of an administrative hearing, alternative dispute resolution, or proceeding to court. For appeals from Corporate

Alliance health plans, the Complaint Review Office will offer claimant a choice between alternative dispute resolution and an administrative hearing. There are expedited procedures for emergencies.

The Role of Alliances in Health Plan Operations

Alliances are responsible for (among other things) ensuring that everyone is enrolled in a health plan, for assuring that health plans provide access for all eligible individual, for conducting the premium negotiations and enforcing the ceilings on the rate of growth in plan premiums, and for oversight of plan marketing.

Enrollment and Access. Any health plan that wants to operate in an area must do so through the health alliance; the alliance then makes all such plans available to its members. Alliances have authority to use financial incentives to encourage health plans to expand into underserved areas, and may assist providers in creating new plans in underserved areas.

Premium Negotiations and Budget Enforcement. In order to obtain the best premiums for their members, alliances will solicit competitive bids from insurers and make sure that premium do not exceed the overall budget. Competitive pressures and incentives will induce plans to offer high quality service at affordable premiums in order to get and retain membership. If the weighted average premium bid exceeds budget targets, the alliance reduces the premiums of each health plan whose premium bid exceeds the average. Premium bids are reduced in proportion to the amount by which the Plan's bid exceeds the target to bring the weighted average of all Plans' bids within the target.

ADDRESSING RISK SELECTION

Risk selection -- particularly the intentional exclusion by health insurers of people with serious or chronic health problems -- is one of the most significant obstacles to health security in our current health care system. Risk selection occurs when a health plan attracts a skewed distribution of health risk in its enrolled population. The problem of risk selection is important because it affects the premiums charged by health plans. If risk selection occurs, health plans that attract relatively healthier enrollees will have relatively fewer claims and can charge lower premiums.¹ On the other hand, health plans that attract

1. Health insurers can generally manage the risks associated with random occurrences of illness and injury in a large pool of enrollees. However, competition in a health insurance market can fail if the enrollment choices of consumers are systematically biased in a way that particular health plans attract a markedly

relatively sicker or higher-risk enrollees generally will have more claims than plans with average enrollment mixes, and will be required to charge higher than average premiums to cover their higher costs. If the premiums of competing health plans reflect risk selection rather than the efficiency and quality of the plans, the benefits of competition -- promoting efficiency and quality -- are diminished.

The Health Security Act addresses risk selection through a series of integrated steps, including: assuring universal coverage and comprehensive benefits; enrollment and marketing reforms; insurance underwriting and rating reforms; mandatory reinsurance of high cost cases and conditions; and risk adjustment of premiums paid to health plans for demographic and health status variations in plan enrollment.

Universal Coverage and Comprehensive Benefits

In the current system, insurers use medical underwriting, preexisting condition exclusions and other mechanisms to protect themselves from adverse selection. They often design their benefit packages to attract younger, healthier enrollees. Under the Health Security Act, everyone will have the same comprehensive benefits package. Health plans will be unable to influence enrollment decisions through the design of their benefit packages. In addition, because all plans will offer comprehensive benefits, there will be less reason for people to change health plans if their health status changes.

Enrollment and Marketing Reforms

Under the current system, health plans can influence the composition of their enrollment through their marketing activities. Under the Health Security Act, enrollment will occur through health alliances, providing all applicants with an equal choice of all health plans. Consumer information about costs, quality and plan design will be provided directly to individuals through alliances and employers, so the opportunity for selective marketing by insurers will be eliminated. The Health Security Act also requires that direct marketing be made to the entire area served by a health plan.

One potential means of risk selection by health plans in a reformed system is to discourage higher-risk enrollees from continuing with the health plan by giving them poor service or failing to contract with providers that can address special needs. Under the Health Security Act, enrollees can be periodically surveyed to detect problems with health plan service. People who switch plans can be surveyed to determine if

healthier or sicker than average mix of enrollees.

they left their former plan because of poor service or inadequate access to specialists. Problems uncovered can be addressed through the state certification process.

Insurance Reform

In the current market, insurers use medical underwriting and a host of other strategies to discourage enrollment by higher-risk people. Insurers can directly affect enrollment of higher-risk individuals by raising premiums or terminating coverage for groups with high claims costs. Under the Health Security Act, all health plans will be required to accept any enrollee who applies for coverage. Plans will not be able to discourage enrollment based on health status. Health status cannot be considered in establishing premiums. Coverage cannot be canceled by a health plan for any reason.

Health Plan Contracting Requirements

Even with enrollment, marketing and insurance reforms, one potential source of risk selection by health plans is their decisions about which health care providers to contract with. Concerns have been raised that health plans will avoid contracting with leading treatment centers and specialists in order to avoid patients with serious health conditions. The Health Security Act requires health plans to contract with academic health centers for the treatment of health conditions that require the specialized treatment expertise of these centers. This requirement will assure that enrollees who need special services will be able to select and stay in any plan serving their area.

Risk Adjustment and Reinsurance Methodology

The Health Security Act requires the National Health Board to develop a risk adjustment and reinsurance methodology to be used by regional alliances. The methodology will assure that payments to health plans reflect expected utilization of services and protect health plans that enroll a disproportionate share of higher-risk people. The Act directs the Board to consider a number of factors developing the methodology, including:

Demographic characteristics. The Health Security Act provides for community rating by health plans. To protect health plans from adverse selection if they disproportionately attract enrollees who are older or who reside in higher cost areas in an alliance, the premium payments by regional alliances to health plans will be adjusted to reflect the demographic characteristics and areas of residence of each plan's enrollees.

Proportion of cash-assistance recipients. The Health Security Act requires the Board to consider the need for premium adjustments to reflect any additional risk that health plans may face by enrolling a disproportionate share of lower-income or cash assistance recipients. Concerns have been raised about the willingness of health plans to serve traditionally underserved people and about the potentially higher administrative and other costs of providing services in underserved areas. If necessary, premiums paid by alliances to health plans that serve underserved areas to reflect any higher costs incurred.

Health status. The Health Security Act requires the Board to consider enrollee health status in developing the risk adjustment and reinsurance system. Even in a reformed system, there is concern that some health plans may face systematic adverse selection which could affect their competitive position in the market.

The Health Security Act provides for several methods of protecting health plans from adverse selection by higher-cost enrollees. The Act anticipates a short-term and a medium-term strategy. In the short-term, we expect the Board to rely on a combination of mandatory reinsurance and health status adjustments based on self-reported health status collected through surveys of plan enrollees. Over the medium-term, we expect the Board to develop and implement more sophisticated adjusters for health status, based on diagnosis of plan enrollees.

In the short-term, reinsurance will be used to protect health plans that attract a disproportionate share of enrollees with high-cost or chronic illnesses. Reinsurance systems are being used in a number of states today as part of insurance reform efforts. Under a reinsurance approach, health plans share the costs of treating higher-cost or chronically ill enrollees on either a mandatory or voluntary basis. If a health plan has a high-cost claim or enrollee, the reinsurance system reimburses a portion of a health plan's payments for these cases. This reimbursement can be based on a percentage of a plan's actual costs, or can be a specific amount based on diagnosis or condition. The health plan pays a premium to the reinsurance fund for this protection.

The Board also could adjust for perceived health status or the presence of chronic conditions in the short-term through the use of health status surveys. This approach relies in health status data collected from health plan enrollees, either at time of enrollment or through surveys of random samples of plan enrollees. Premiums would be adjusted to reflect the differences in health status across plan enrollment.

In the near future, more sophisticated risk adjusters can be available that are based on the diagnoses of individual enrollees. Initial research indicates that these adjusters should be more accurate than other approaches, but no system has been fully developed and implemented that relies on these potentially more accurate measures of risk.

Over the last few years, the Department of Health and Human Services has sponsored and conducted a substantial amount of research looking at the development of risk adjusters for health status, primarily related to the Medicare population. To accelerate development of risk adjustment methodologies for the under-65 population, the Department is currently developing a work plan that encourage research efforts in this area. The work plan will call for internal research efforts and for sponsoring research and demonstrations by outside experts.

CORPORATE ALLIANCES

Employers of sufficient size (as well as certain Taft-Hartley plans and rural electric and telephone cooperatives) will have the option to form corporate alliances. Any private employer with over 5000 full time employees nationwide may elect to form a corporate alliance. Alternatively, these large employers or eligible sponsors may choose to participate in the regional alliance.

A corporate alliance will serve the same functions as a regional alliance, under similar requirements. (ERISA is amended accordingly.) Corporate alliances must offer health plans that provide the nationally guaranteed comprehensive benefits, must hold an annual open enrollment, and provide comparative information about health plans. Grievance procedures and reporting requirements applicable to regional alliances also apply to corporate alliances, as do administrative simplification mandates.

Corporate alliances must offer at least one fee-for-service plan and at least two other plans. Corporate alliance plans must accept all eligible enrollees on a first-come first-served basis and may not terminate enrollees or limit coverage for the nationally guaranteed comprehensive benefit package. Exclusions for pre-existing conditions and waiting periods are prohibited. Plan premiums in the corporate alliances must stay within the nationally established target.

A corporate alliance makes premium payments directly to health plans, using any type of insurance rating arrangement. In addition, corporate alliances will be required to pay a surcharge, to help support the financing the cost of medical training and research in academic health centers, that will be otherwise supported by premiums in the health alliance.

In some cases, one spouse may work for an employer that has formed a corporate alliance while the other works for an employer in the regional alliance. The couple can choose a health plan through either the regional or the corporate alliance. Whichever alliance the couple chooses, both employers would be required to make a premium contribution.

The Health Security Act establishes minimum reserve standards for self-funded health plans and a guarantee fund to assure payments in the case of insolvency of a self-funded plan. Contributions to the Fund are made when receipts are needed to maintain the solvency of the Fund.

Employers that form a corporate alliance will periodically have the opportunity to switch to the regional health alliance. Once in the regional alliance, there is no opportunity to return to corporate alliance status. For corporate alliance eligible employers which join the regional alliances, community rating and discounts will be phased in over eight years.

CONCLUSION

Mr. Chairman, there is room for debate about the details of this plan. But the basic principles are not open to compromise:

- * All Americans must have health coverage.
- * Everyone must make a contribution.
- * Health care quality must be preserved and improved.
- * Consumers' choice and access to care must be enhanced.
- * The rate of inflation must be slowed.
- * Administrative requirements and costs must be streamlined.

Health plans are a crucial component to making translating principles into reality. Thank you for the opportunity to discuss these aspects of the Health Security Act; at this time, I would be happy to answer any questions you may have.

Mr. WAXMAN. Under the President's bill, all health plans with low cost sharing are required to offer a point-of-service option to their enrollees for all services with no deductible and with 20 percent cost sharing for most services.

On our next panel, Ms. Anna Lore, the manager of the Kaiser Health Plan in North Carolina will recommend that the point-of-service feature be optional for HMO's. Making this a mandatory element of any health plan, she argues, will significantly increase the cost of approximately 40 million HMO members now covered by basic HMO coverage and many others who would want to join HMO's as they currently operate—I am quoting.

Why is the point-of-service option mandatory with respect to all low cost sharing health plans under the President's bill? Why not let market forces operating within the regional alliance determine whether or not HMO's offer point-of-service?

Ms. FEDER. Mr. Chairman, let me begin my answer by clarifying the way in which HMO's do operate under the plan. It is perfectly consistent with the Health Security Act that HMO's offer themselves to potential enrollees on the basis on which they currently operate, and that is that consumers would be limited to the providers in that plan.

But we have required them to offer what is essentially a separate plan at a separate premium, which is that same network but with a point-of-service option so that consumers in that plan could go outside. So both options continue to exist under the Health Security Act.

The reason we have required these plans to offer themselves with a point-of-service option has to do with our considerable concern with consumer choice. We want to be very certain that consumers at all times in choosing a plan are knowledgeable about what they are doing and have the opportunity to have—to use outside providers if they wish to do so. And so it is for that reason that we have required that HMO's offer this separate option as well as the one with which they are most familiar.

Mr. WAXMAN. But how would consumers be disadvantaged by Kaiser's proposal if they knowingly choose to enroll in an HMO without a point-of-service option?

Ms. FEDER. The issue is—the emphasis there is on the “knowingly,” and if they knowingly choose that option they still have that option. But we also want them to have the option of the Kaiser network providers with point-of-service to make certain that they are accurately, or clearly exercising the option they intend.

Mr. WAXMAN. Ms. Lore from Kaiser will also testify that an initial enrollment in regional alliances should be limited to employer groups with no more than 200 employees, rather than the 5,000-employee threshold proposed in the President's bill. She points out that the start-up of regional alliances could be chaotic because of the large number of transactions that would occur as millions of people select among dozens of plans.

She will argue that alliances of this size would still contain enough people to be viable purchasing units and would be more manageable.

Dr. Karrh, with the corporate health care coalition is going to testify that using the 5,000-employee threshold regional alliances

would, on average, control 70 percent of the population in every State, leaving roughly 1,200 corporate alliances with 17 percent of the population and Medicare with the remaining 13 percent.

He urged that the size of the regional alliances be reduced so as to increase the relative size and purchasing leverage of corporate alliances, and he suggests a threshold of 100 employees, which he estimates will cover nearly one-third of the population.

I am interested in your reaction to this. How many people do you estimate will be covered through regional alliances under the President's 5,000 minimum threshold? How many would be covered if the threshold were lowered to 200? What difference would reducing the size of the regional alliances make in their ability to constrain costs?

Ms. FEDER. To begin with the numbers, if I may, the regional alliances, we estimate, would cover nationally about 73 percent of the population. That would clearly differ from State to State, and so it appears that that estimate is consistent with the one that you quoted.

The further question of the smaller size may also be consistent with the estimate between one-third and one-half and we are double checking the estimate for you.

Now, let me turn to the broader question about the implications of smaller alliances, and I guess I want to go back to why it is that we have defined the alliances and structured them as we have, and there are several reasons that I would like to go through.

The first reason that we have established a relatively large alliance has to do with our concern and desire to restore the community that health insurance is supposed to be about, and our objective has been to establish as broad a community as possible for spreading risks, and that is a critical concern that we have in terms of returning insurance to its initial function.

Our concern is that smaller and multiple pools, which happens if the size goes down for the alliance, leads to a continued fragmentation of the marketplace in which there is a segmentation of the healthy from the sick, the old from the young, a fragmentation of the marketplace very much like what we have today.

We have noted over the past several weeks, Mr. Chairman, that the Health Insurance Association of America has been a very strong proponent of this alternative point of view, and consistent with their capacity to benefit from the current marketplace, and that is a concern that we have and we want to eliminate the possibility of benefiting from that kind of risk selection.

A related issue and a second issue has to do with administration if we go to smaller and multiple pools. If we want to protect people in that kind of environment and ensure that premiums are appropriate to their circumstances, it requires an enormous administrative, an enormous bureaucracy and regulatory apparatus essentially to regulate tens of thousands of plans, and it is our desire to simplify, not increase, the bureaucracy in the system.

A third reason that we have gone to larger alliances has to do with individuals, making it easy for consumers in the system addressing the issue of individual choice and portability. We know that in today's marketplace we face a tremendous concern and confusion and disruption for consumers as they have to change health

plans when their jobs or other aspects of their life circumstances change. And one of the key advantages of having the alliances as we have structured them is to eliminate that need, because for the majority of Americans it will not matter when you change your job or your circumstances change. You will stay in the same pool and therefore the same health plan. So portability is greatly facilitated by the arrangement we have put forward.

Fourth, and you asked particularly about cost containment. As indicated in my opening remarks, we believe that by creating a managed marketplace—that is the job of the alliance, is essentially to create a forum in which individuals can choose among competing health plans, and that is the mechanism which we believe will contain health care costs.

If we don't have that large pool, we will not have that marketplace with its related effectiveness, and in those circumstances the only way that we will be able to control costs would be to directly regulate health care premiums.

And finally, we believe that the structure we have created allows a pooling of dollars in which the alliance collects the money from the employers and individuals and the government sources and then pays it out to plans in a way that enables us to deal in a relatively simple fashion with the payments for two-worker families, with the administration of discounts, the guarantee affordability, and that that greatly simplifies the system in the manner that we have put forward, and it would be far more complex were we to make alternative arrangements.

Mr. WAXMAN. Thank you very much.

Mr. Bliley?

Mr. BLILEY. Thank you, Mr. Chairman.

Ms. Feder, we are going to take one more shot at people switching plans in the alliance. At our last hearing you said our example was not realistic because we had the fee-for-service plans with a higher premium than the HMO; and second, we had people shifting from the HMO into the fee-for-service plan. You stated that you did not agree with either assumption. You said that in many instances the fee-for-service will have a less expensive premium and people will want to shift into managed care plans anyway because of the low cost sharing.

Well, we fixed up the example to accommodate your concerns. This example is based on actual plans and premiums from the Government Employees Health Plan. Blue Cross/Blue Shield and Government Employees Health Association are fee-for-service with a PPO option.

Maryland IPA is an HMO. Its premium is significantly higher than the fee-for-service plans. In the first year, the average weighted premium for all plans would be \$5,136. The second year each plan receives its cap update, but two of the individuals in the fee-for-service plans have seen the light and switch into Maryland IPA because of the low cost sharing. The weighted average is now 55/48.

Now, we have our old problem. The weighted average premium \$181 over the allowed per capita amount. Then the hammer hits. Section 6001(d) reduces every plan's update in the next 2 years.

Ms. Feder, this possibility has been pointed out in working papers written by the Physician Payment Review Commission. In a paper entitled "Expenditure Limits in Health System Reform," by Jack Hoddeley, he states, for example, "If a substantial number of consumers during a particular open season switch from high cost sharing plans, that is, fee-for-service plans, to low cost sharing plans—HMO's—then there would be a net shift of expenditures from off-budget to on-budget status. Thus, even if the price and volume of care grew at the allowable rate, total expenditures included in the budget in the alliance would be out of compliance."

Would you please comment on this example, and comment on Jack Hoddeley of the PPRC?

Ms. FEDER. Yes, sir. First of all, in terms of the real life examples, and I would have to check them, I want to talk about the general structure of the Federal Employees Plan. The Federal Employees Plan differs from the proposal that we are making in a couple of key respects.

First, the benefits across plans are not standardized in the Federal Employees Plan, and we have then a selection that occurs in that, in the Federal Employees Plan, that is one more complicated than that which we propose, and (2) has historically head to some risk selection issues because of differences in benefits.

We would alter those and provide consumers with a much clearer choice, which we believe would affect their decisions in this marketplace.

Second, there is a stronger incentive in the President's proposal for choosing plans, for consumers to choose plans that provide value for the dollar. In the President's plan they will get a contribution that is 80 percent of the average cost plan, but then the decision—their out-of-pocket obligations will be a function of the cost of the plan they choose. That means that if a plan is low cost they may have to pay nothing additional in order to—out of their own pockets. Their employer contribution may cover the full cost.

Under the Federal Employees Plan, there is a maximum payment made of 75 percent of a premium, so there is a lesser incentive in that regard.

A third point has to do with the nature—I realized there were three, not two, differences I wanted to point out. A third point has to do with the fee-for-service plan in the President's plan that again differs from current arrangements, and that is that fee-for-service plans will be operating in a very different environment in which they too are constrained to live within their premium bids and will have a stronger incentive to do so for the reasons I previously indicated.

So, for all of those reasons, I would say that I would question the assumptions underlying your charts and will be happy to continue exploring them with you as you put them before me.

Mr. BLILEY. Then are you saying that the PPRC's analysis is wrong?

Ms. FEDER. I am saying that there are other factors to be taken into account that call that into question.

Mr. BLILEY. Why do you exempt the Federal employees from participating in this plan until 1998? You tell every other business they got to come in right away, but you say, Oh, Congress, admin-

istration, you guys don't have to come in until 1998. Don't we run the risk of saying, "There they go again, they put everybody else in these things but they exempt themselves"?

Ms. FEDER. Mr. Bliley, let me be very clear that it is our—our perspective really is much closer to saying to the American people that what will work or what is working with modifications for Congress and the President is what we are giving the American people. The only reason that we have delayed or timed the integration in that way is for an ease of administration. We are quite concerned that for Federal employees as for all Americans that this transition be clear and simple and as undisruptive as possible, and that is why we have chosen that schedule.

Mr. WAXMAN. Thank you, Mr. Bliley.

Mr. Brown?

Mr. BROWN. Thank you, Mr. Chairman.

People later on today, Ms. Feder, some are going to say that we should not have exclusive alliances, that prices can be held down with competing health alliances. Why the exclusivity of them?

Ms. FEDER. Well, Mr. Brown, it goes back to what I was laying out for the chairman. Again, the objective we have in an alliance is to create the true community pool so that risk is spread so that individuals, not employers, choose health plans and so that we end the kind of cherry-picking that goes on in the insurance marketplace today.

It is our concern that if we allow multiple competing pools that once again where employers or others are choosing which one to join and the pools can decide whom to exclude that we are back to that segmentation of the marketplace in which the sick are distinguished from the well, the old from the young, we face all the problems we do today. So it is critical to us that we establish this broad pool to establish that community.

Mr. BROWN. Others say that we should—because this whole health alliance concept is pretty untested and we are going to all of a sudden, come some date next year, the following year, have this whole system of health alliances. I hear people here and at home say often, "Why don't we test it somewhere? Why don't we do a more incremental approach? Why don't we do some sort of pilot project kind of health alliance concept?" What is the answer to that?

Ms. FEDER. Well, I guess the first thing I was saying is that we are—we do have examples of alliances around the country. We have built on real life experience as we have developed this plan, and so we feel that that is built in to a considerable extent.

Second, we are talking about States deciding and designing their systems consistent with their citizens' needs. That builds a lot of variation into the system from which we can continue to learn and improve.

And then finally, I would say, we have been experimenting. Over the last decade and before, we had a number of experiments in different States, really fairly sizable experiments, with various aspects of reform that fell short of the kinds of reforms that we are proposing, and it is critical, we believe, in order to guarantee security and affordability for Americans that we move forward now on a comprehensive system.

Mr. BROWN. Another set of comments that I hear frequently is that the President's plan will cause the elimination of fee-for-service medicine as we know it, and that once the plan is fully phased in Americans will in effect have no choice. We will have no choice but be left only with managed care options. Respond to that criticism.

Ms. FEDER. Yes. We have had discussions with many economists on that particular issue, and there are actually some who argue that the changes we are making will enable the survival of fee-for-service systems and the choice of those systems.

Essentially, we are enabling or giving fee-for-service plans both an incentive and the tools to manage their costs to be affordable and to keep that option viable. When everyone is enrolled in a plan, a fee-for-service plan like other plans will have information on the practice patterns of its providers which will enable it to identify the providers who are providing inappropriate or excessively costly services and to essentially adjust the fees paid to those providers in a way that penalizes them for that kind of behavior and holds the costs in check.

In general, fee-for-service plans will be operating under fee schedules negotiated with the alliances, but that will enable them broadly to keep their costs under control. So, both in terms of being able to oversee the practice patterns and negotiate appropriate payments to providers, fee-for-service plans will have tools they don't have today in order to keep them operating in the system.

Mr. BROWN. What percentage of Americans now have pretty much full physician choice? Do you know?

Ms. FEDER. When you say full physician choice, you know, there are several—there are different ways to measure that and I would prefer to give it to you for the record. I think that is the safest way to answer the question.

Mr. BROWN. Thank you. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Brown.

Mr. McMillan?

Mr. McMILLAN. Thank you, Mr. Chairman.

Dr. Feder, if it makes sense to defer or waive, because of the difficulty of transition, Federal employees under the plan, why doesn't it make sense to do the same for others?

Ms. FEDER. Well, I think that the issue there is that we have a national plan that involves, I believe, 9 million people. We require the corporate alliances similarly to become applicable at that time. Those similarly are national plans. I think our approach has been consistent and it does make sense.

Mr. McMILLAN. OK. Well, I think it is important to make that clear to the public because there is a perception out there that the government makes exceptions for itself that others don't have access to.

Ms. FEDER. And we certainly want to dispel that impression.

Mr. McMILLAN. I want to focus just a minute on your estimate of those who would be participating under corporate plans because I have heard very different figures that indicate perhaps at the outset, perhaps, 12 percent would be under corporate alliances as opposed to, I think you said possibly 27 or 23 percent.

Ms. FEDER. Shall I clarify? Because I think we really have a similar number.

What I said was 73 percent of the population, of the whole population are regional. I have about another 9 percent in corporate. The remainder is Medicare. I am including Medicare in my numbers.

Mr. McMILLAN. So then the 12 percent is right?

Ms. FEDER. It seems close to what we are estimating.

Mr. McMILLAN. You know, we could spend a lot of time talking about the range of incentives and disincentives for corporate alliances to continue. I think on balance it will be that they will not continue. It will be very easy for large corporations simply to say, "Well, with the regional alliance available, why should I provide care to my employees?"

And I think it will be the exception rather than the rule of those who continue to offer their own plans, just from my own perspective. I don't know whether that will be true or not. It would be interesting to see what assumptions are over time in terms of that change. Because what really concerns me, as I have said before, about your approach as opposed to alternative approaches is that I don't think you engender competition. I think you do the opposite.

And you have spoken today about small plans, multiplicity of plans, fragmentation of the marketplace, and so forth. I don't think that would occur. If you are setting what is standard care and you are basically saying you cannot exclude anyone, you then force risk pooling on the marketplace, which I would agree with. I think you have got to do that.

But I think there are other ways to achieve it without overly concentrating purchasing, which is what I am concerned—is a fundamental concern about your approach. And, you know, I think we need to examine that in much further detail.

Ms. FEDER. May I respond, quickly?

Mr. McMILLAN. Yes.

Ms. FEDER. Because I think that we certainly agree that we need to have the new rules for plans that you are describing. I think that that issue needs to be separated from the pool in which plans compete.

When we set up the alliance and a pool, we set up an independent enrollment mechanism, independent of the plan's marketing behavior, and we believe that that structure makes it harder for plans or essentially gives them very little opportunity to selectively market.

If we don't create that pool and rely only on the rules, plans still have a tremendous opportunity to selectively market, and then it gets us into a cycle of greater regulation to try to enforce those rules. So I think that that is a distinction that we have thought about.

Mr. McMILLAN. Well, perhaps you have thought these things through, but I mean I think you could have some rules. If you develop one case of refusal to offer a policy that was offered in the general area or the State or whatever division you want to consider, then the penalty is loss of tax deductibility on the sale of the plan. I mean you just don't accept that.

And I think there are ways to do that which then maximizes choice and competitiveness without controlling it.

Ms. FEDER. Well, then again I think that the competition that we are—where we are concerned is having this competition among plans in a pool. We don't see a need to have competing alliances to have competition, but clearly we will continue to discuss it.

Mr. McMILLAN. Could I—I have several other questions.

Mr. WAXMAN. We are going to have a second round.

Mr. McMILLAN. OK. Fine. Thanks.

I will get to my next question later. Thank you.

Mr. WAXMAN. Mr. Kreidler?

Mr. KREIDLER. Thank you, Mr. Chairman.

Dr. Feder, some of the critics in the insurance industry are concerned that there will be adverse selection against fee-for-service plans unless employers are allowed to steer employee groups into them. Do you think this is a realistic concern?

And second, is that concern enough to outweigh the benefits of free choice of plans which the alliances would guarantee?

Ms. FEDER. Mr. Kreidler, we don't think that there is enormous concern and we think that choice is an extremely important element of our structure. The specific issue here is that all plans will be held accountable for delivering the guaranteed benefit package.

All plans will be required to contract with academic health centers. States may also impose requirements for contracting with centers of excellence. We think that all of these features along with the risk adjustment and reinsurance mechanisms we are proposing will prevent adverse selection, and consequently, people will have an appropriate choice of plans without negative consequences for those plans.

Mr. KREIDLER. I guess I don't understand exactly what the insurance industry's criticism is. Are they saying that employers should be in a position of making sure they steer healthy employees to fee-for-service? Is that what they are trying to say in a round about way?

Mr. CLAXTON. If I could answer this one. It is kind of hard—I was just sitting there as you asked the question trying to think this through. There are going to be people in the market who have poor health and are recognized as higher risk individuals, and in universal coverage in any way you cut it they are going to be in the market.

And it seems to me the only way you can try and deal with selection is either try to use reinsurance or some sort of adjustment, which we are trying to do, or to say that those people have no choice, their fellow employees have no choice or we are going to do some kind of risk rating, and we just don't think that second set of alternatives is appropriate.

Mr. KREIDLER. Very good.

Let me also commend you for the independent analysis that was done as to the financial numbers for the health care plan that independently were verified by Lewin and Associates. I found that interesting to read and look forward to seeing more comprehensive notes showing that your numbers do hold water. And I am glad to see that for those of us who have signed on as cosponsors of the bill. We have been vindicated for doing so, with the assumption

that you were correct, and it is good to see that happen. So I commend you for that.

Ms. FEDER. I am sure, Mr. Kreidler, you had confidence in us, but I am glad we delivered.

Mr. KREIDLER. Thank you very much.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Kreidler.

Let's see. Mr. Hastert?

Mr. HASTERT. Thank you, Mr. Chairman.

Here we go again. Let's lay out a scenario. I talked with my largest employer in my district yesterday. They have well over 10,000 employee families in my district. They said, basically, that they are interested in staying with the self-insured option because they found that 50 percent of their costs are attributable to 5 percent of their employees and 80 percent of their costs are attributable to 20 percent of their employees, and 5,000 employee families that didn't take one cent of claim last year.

So, when they self-insure, they get a break right off the top, and they manage health care costs by very closely managing that 5 percent of the population and then also managing that other 20 percent of the population. Because you know who they are. They are in the doctor's office. They are in the hospitals. And by managing the contracts that they have with the hospitals and the contracts that they have with the HMO's and the contracts they have with individual doctors, they can manage those costs.

And clearly, their costs are well below the costs for the general population, which will be the cost for the average plan.

Now, in your reform plan the Metropolitan Statistical Area is the only delineated boundary that a health alliance has to cover.

Now, in the Statistical Area where my district is located, there are approximately, at last count, about 52 major corporations that have over 5,000 employees.

Now, clearly those corporations that have good health care management costs are going to opt to stay and pay the 1 percent fee, and are going to opt to stay with their own plans for the next 10 years. They have 10 years to phase, is that correct?

Ms. FEDER. They can choose at various times. Whenever they choose, they have 8 years—it phases 8 years.

Mr. HASTERT. Well, that is even more advantageous.

Those companies that haven't been able to keep their grasp on health care costs are going to go into the health alliance. I mean that is cost effective for them to do. Plus they can spin out their retirees so that they lose that cost. That is a great advantage—could be a great advantage for them.

Now, the question is will the remaining 6 or 7 million people in that Statistical Area—I am sure you have the statistics, I don't right now—pick up that cost. And, you know, if the cap is 7.9 percent per little employer, the guy who has 10, 15, 60, 150, or 2,000 employees, if they pick up their cost of 7.9 percent plus a 2 percent employee contribution to the health alliance, then there is a lot of population out there that aren't employed that the government is going to have to pay for.

And let's say 40 of the 52 companies opt out but 12 companies, because they have high expenses dump their population into the

health alliance. Thus, you have a situation where you have beneficial selection for a group of people because they can manage that population.

And for the rest of the health alliance, you have adverse selection, because you got everybody else the Cook County Hospitals, the crack cocaine babies, the people who don't have insurance at all today, AIDS patients, so everybody else ends up subsidizing or cross-subsidizing for that health care.

I don't see how we can get any semblance of fairness out of this. Would you care to elaborate?

Ms. FEDER. Yes, I would be glad to.

First of all, the statistics that you gave for this corporation sound very similar to me to the—essentially to the general characteristics of the population. This doesn't sound like a unique population at all. We do find that the health care costs are concentrated among a small proportion of the population because that is what happens when they get sick.

When they get sick it is expensive, and a minority get sick. So that distribution didn't sound particularly strange or unusual for that. It sounds like the general population distribution.

Second—they didn't sound unique. They are able to keep their health costs under control because they sound like exactly the kind of large employer that we have wanted to give an opportunity to self-insure because they have, it sounds, been effective and aggressive in working with doctors and hospitals to deliver health care efficiently.

What we are doing through the changes and the incentives that we are putting forward for health plans as well as the creation of alliances, we are now extending that capacity to appropriately manage health care efficiently to the rest of the marketplace. And so now small employers or employees in small firms will be able to benefit from that kind of management as have the population in large firms, or employer contributions from small employers will be lowered as they have been for large employers. So, we really are making the whole marketplace work more effectively.

Third, you talk then about spreading the risk, and there is a legitimate argument, and it is why we have made those rules for Metropolitan Statistical Areas that we want to spread it over as large a pool as possible. And, in fact, the concerns you express are really quite consistent with the reasons that I am putting forward that we need to have relatively large alliances with many people and many firms in them and allow the opting out or the self-insurance only for those very large firms who are able to manage care appropriately.

So, we think that what we have put forward does appropriately spread risk, does appropriately allow those corporations that have the capacity to manage care effectively to continue to do so.

Mr. HASTERT. But it would just seem to me, and I know I am treading on your time, Mr. Chairman, but just a comment on this thing.

It would seem to me what you are doing in this case is setting aside entities that have the benefit of beneficial selection. But those who haven't done a good job of dumping off into health alliances and then creating a situation where there is a huge cross-

subsidy out there that everybody else has to pick up, that aren't fortunate enough or have the numbers of employees that they can't do this. They have adverse selection that they have to deal with. As a matter of fact, they even have the adverse selection dumped on them with the big corporations that didn't do a good job.

And so what you are doing is having the general population cross-subsidizing over a Statistical Area and letting everybody else that has the benefit of beneficial selection to walk away.

Mr. WAXMAN. Mr. Hastert, your time has expired. But you may respond, Dr. Feder. Then we will have to move on.

Ms. FEDER. Just very quickly. I would say, number one, we believe we have kept that to a minimum by setting the opportunity for the self-insurance at 5,000 or larger; and two, it is a reason that we are including the assessment of 1 percent of payroll for those corporations to be certain that we are including them or expecting them to contribute in broad communitywide responsibilities.

Mr. WAXMAN. Mr. Wyden?

Mr. WYDEN. Thank you, Mr. Chairman. And welcome again, Dr. Feder.

On this matter of the size of the alliances, I mean I think there are two questions that I and I think some other members have. One is, you know, it is hard to see the proposition that corporate innovation only begins when a firm has got over 5,000 people. I think that is a troubling kind of premise in all this.

And second, I mean I heard even as recently as last week, you know, from businesses in my area. They say, "Look. This doesn't seem right. Big business doesn't have to do the same thing that poor people and middle-class people have to do." And I think that that is something of an emotional knife in the gut, you know, to the President's proposal. I think it hurts the President's proposal, and a lot of us want to see it pass.

The question that I have, I guess, is why not look at restructuring the employer contributions inside the regional alliance so that all employers get a fair shake and that all employers are in a position to monitor and influence costs? It seems to me that there you could then get at both of the problems that I hear. One, that people are innovative who aren't, you know, over 5,000. Second, you know, the fairness kind of question.

I wonder if you all are looking at that at this point?

Ms. FEDER. Well, Mr. Wyden, first in terms of the concern that somehow the consumers are disadvantaged in regional alliances, I want to be—I think we all need to be real clear that they are getting maximum choice. That everyone is guaranteed choice under the President's proposal. Corporate alliances too must offer choice. But the choice is, indeed, broader in the regional alliances. So I don't think there is a disadvantaging there.

And I have been through many of the reasons that we think in order to have individual choice and to have true community rating that is why we have structured this the way it is.

I would have to pursue further with you the specific proposal that you are making about giving employers an incentive because we really think that what we are doing is focusing on individual choice and that that change in the marketplace is the best way to

hold plans accountable for efficient delivery of quality care. But we are happy to explore the suggestions that you put forward.

Mr. WYDEN. Did you all ever look at the idea of having employers pay 80 percent of the cost of the plan picked by an employee instead of having the employer share be fixed? Did you all study that?

Mr. CLAXTON. Yes, we did, Mr. Wyden, and the reason we didn't go with it were probably two. One is that to make the consumer the most cost conscious we need to have them bear the full cost of choosing more expensive plans.

And second, and quite frankly, administratively it is very difficult to collect from employers, from the millions of employers that exist in this country, different premiums based on what plans their employees choose when employees move from place to place, et cetera. I think you would be adding an administrative burden potentially that would outweigh whatever benefits that might be perceived from that.

Mr. WYDEN. Well, those sound like very plausible reasons. All I would say is I think around the country employers are looking at this and they are saying, "We're being read out of the equation."

And the individual incentives is clearly a sensible approach, but I think Mr. Brown, for example, one on our committee, has made the case that a lot of employers have done some very innovative work in terms of preventive health, cost containment, and I hope as we go we will look for some ways to keep them in the equation.

Let me ask you about one other matter, can kind of—sort of flip side of, you know, risk selection and risk adjustment. The two kind of go together.

Dr. Newhouse of Harvard recently said that risk selection can be extremely profitable for an insurance company. For example, he said that profits could be well over 50 percent for an insurer who had great ability to select low risk enrollees.

Now, even if alliances are extremely good at dealing with risk adjustment—to your credit, you and I have talked about how this is pretty much a science, you know, in its infancy. Even if, say, they are 60 to 70 percent accurate in terms of risk adjustment, you still got a situation where insurance companies are going to be in a pretty good position, if they are good, to cream skim and cherry-pick through the new market, just as the ingenious ones have been out there cream-skimming and cherry-picking in the past.

What is your sense about how we could deal with that?

Mr. CLAXTON. As Dr. Feder pointed out in her opening statement, we really have what we think is an integrated strategy to deal with risk selection by insurers and it just doesn't involve, you know, risk adjustment of payments or reinsurance. It starts out with universality of coverage, which means everyone is covered so certain—it goes to the kind of changes in enrollments. When you have people enrolled through alliances there is not the ability to have health screening.

We have eliminated risk rating and the other things that allow insurers to disadvantage high risk people from getting coverage. We have the alliances approving marketing materials and a requirement that marketing materials be made available to everyone in a plan's service area. That and individual choice and enrollment

through the alliance means that the insurer really can't target people who are healthy err.

In terms of disenrollment, we have a quality of care system which will try to identify plans that have poor quality for high risk patients, disenrollment surveys to find out why people left. If it is because they don't have access to the types of providers they need, we can identify that and take regulatory steps to deal with it. And each plan has to contract with an academic health center, at least one, or as the Secretary provides, to make sure that the kind of appropriate level of care is available in all plans. So, we think we have a very comprehensive strategy to deal with what Dr. Newhouse was concerned with.

Mr. WYDEN. My time is up. I would only say that the problem with that, and those are sensible ideas, is it is going to take a while to start getting that kind of information back into the system.

What Dr. Newhouse is predicting is, in effect, on day one you have got real possibilities for cream-skimming under the new system. You got insurers that are going to be great at still finding the low risks. You got risk adjustment that is going to be in its infancy. People are going to be in a position to make these illicit profits, in effect, right at the outset, and downstream we will start getting this data that you and I think are very useful, and I would hope that we would look at that area.

Mr. WAXMAN. Mr. Wyden, your time has expired, but it looks like Dr. Feder wants to respond. I am going to have her respond briefly so we can then move on.

Ms. FEDER. Very briefly. I would just say that we share your concern at making this workable because we have got to do better than the present system.

And I would just add that one of the reasons that I am so delighted to have Mr. Claxton not only at the table but as part of this process in my office at HHS is because of his experience in dealing with precisely these problems in the insurance industry. So we are working on them.

Mr. WAXMAN. Thank you, Mr. Wyden.

Mr. Moorhead?

Mr. MOORHEAD. Thank you, Mr. Chairman.

Dr. Feder, at a hearing before the subcommittee on November 22nd, Ken Abramowitz, a Wall Street analyst from the firm of Stanford and Bernstein, testified concerning the potential for private investment capital in the health sector of our economy if the Clinton health plan becomes law. Mr. Abramowitz advises virtually all the major banks and mutual funds in the country and in Europe as to how to invest money in health care. During the past 12 years Mr. Abramowitz was voted the number one health care analyst for 10 of those years. So I think we have to pay some attention to his analysis.

During his appearance before this subcommittee he made the following observations: The Clinton health care plan is about \$50 billion to \$100 billion underfinanced. The review of the drug pricing called for in the Clinton plan will seriously impact access to capital for the drug industry and 50 to 75 percent of all biotech companies

could go bankrupt within the next 5 to 10 years if the Clinton health care plan is enacted.

If the Clinton health care plan passes, he would advise his clients to sell all their health care stock and all their health care bonds. If Congress wants to nationalize the health care system, it should not expect the capital to be there. To quote Mr. Abramowitz, "In effect, the Health Security Act says, 'don't invest in health care. We want to live off of historical capital. Don't put in any new capital. We are going to price control and we are not even going to tell you what the rate of return is. All we know is we don't even know if there is going to be a rate of return. People will put the money in other things.' You can't socialize 15 percent of the economy and not socialize the other 85 percent and expect resources to be there."

The Clinton health care plan is an untested theoretical model. We have to think about how it will work in the real world. Like it or not, part of the real world is investment capital and the plan can't work without it.

This is one of the reasons that we on our side of the aisle have wanted your figures, your background, which we haven't gotten, though it has been promised over a number of months. But without it, we can't tell whether Mr. Abramowitz is right or whether your theoretical plan will work. There is no way we can come anywhere close to analyzing it.

Do Mr. Abramowitz's observations concern you at all?

Ms. FEDER. I disagree with many of the things that you attributed to Mr. Abramowitz, and let me say a couple of things.

Mr. MOORHEAD. Well, these are just statements he made before our committee.

Ms. FEDER. Yes. No, I understand that and I was going to just respond.

One, I would want to say again that I hope to have that information for you in the nearest future, and that I would just point to the study that Mr. Kreidler mentioned in which our estimates had been validated.

Then to go on to the specific remarks, neither we nor, I am sure, the Congress have any intent to nationalize or socialize the health care industry. What we are talking about is changing the incentives in what would continue to be a private system and bring an end to the kind of profiting that Mr. Wyden was describing, so that profits in this industry come from the efficient delivery of quality care.

With respect to the underfinancing, we disagree completely, and as I indicated, our estimates have been validated. With respect to the specific comments on prescription drugs, we will be providing additional information to demonstrate that we are indeed by providing universal coverage expanding the demand for prescription drugs so that that industry will be quite healthy while creating a set of incentives so that prescription drugs will be appropriately used because they are covered to reduce the need for other highly expensive services. So we have, we believe, addressed those concerns.

Mr. MOORHEAD. Well, I accept your statement that your figures have been validated and so forth, but we don't have any way to

judge whether Mr. Abramowitz is right or whether you are right until we get some of those figures.

Ms. FEDER. Yes, sir.

Mr. MOORHEAD. And it isn't fair to come in 2 days before we start marking up and say, "Well, here are the figures," because there is no way that we can begin to analyze them. We are dead in the water.

Ms. FEDER. Your point is well taken, Mr. Moorhead, and I hope you will have them well in advance.

Mr. MOORHEAD. Thank you.

Mr. WAXMAN. Thank you, Mr. Moorhead.

Mr. Greenwood?

Mr. GREENWOOD. Thank you, Mr. Chairman.

Dr. Feder, I want to address to you a question that I addressed within the last couple of weeks to Dr. Rivlin and to a fellow by the name of Jack Lew with White House staff. We were unable to get answers from either of them. We have been promised answers from both of them which have not been forthcoming.

I would like to turn your attention to page 995 of the Health Security Act, section 6002 (c). Section (c) provides the update for the average national per capita spending for the years 1994 and 1995. During these 2 years there is no premium cap, global budget, nor other price controls. Consequently, health care spending will increase at the level determined by the market.

Over the last 5 years this rate has been approximately 10 percent annually. Compounded for the years between 1994 and 1995, those 2 years would give us a cumulative update of roughly 21 percent by the year 1995. Consequently, actual spending should increase by 21 percent over this time. That is what we would expect would happen.

Now, let me read lines 1 and 2 on page 995. "The total cumulative update under this section shall not exceed 15 percent."

Ms. FEDER. OK.

Mr. GREENWOOD. With me?

Ms. FEDER. I am with you.

Mr. GREENWOOD. Great.

Ms. FEDER. I got the page.

Mr. GREENWOOD. Good. Good.

Simply put, instead of using actual expenditures for the calculation of the baseline per capita amount for the initiation of the Act, the bill is mandating an across-the-board reduction in the baseline. In the real world, expenditures will have increased by 21 percent during 1994 and 1995. In the world of this bill, expenditures are allowed to increase only 15 percent over this time frame. This is a huge difference since these percentages would be applied to over approximately \$600 or \$700 billion.

This could lead to a reduction in the baseline per capita amount, which is the foundation of the premium cap, of tens of billions of dollars. This is confirmed by the chief actuary at HCFA who stated publicly, "the actuarially determined premiums for the first year of reform, 1996, are reduced by nearly 25 percent by the global budget and the associated Federal subsidies are reduced by more than 40 percent by the impact of the global budget."

Dr. Feder, these two lines of legislation, which constitute only 11 words, are singlehandedly generating the vast majority of the bill's up-front savings.

Two questions. First, in the previous draft, the 15 percent cumulative update increase applied to 3 years—1994, 1995, and 1996. By now applying this cumulative update to just 1994 and 1995, doesn't that have to change the entire scoring of the bill, particularly your estimate of what the initial premium will cost?

And second, why is the administration performing this baseline reduction in the first place? I have never seen a baseline calculation that doesn't use actual data.

Ms. FEDER. Mr. Greenwood, I am not certain that I can address all your concerns and we will provide a detailed answer for the record, but let me clarify.

First, with respect to the basis on which we have made the estimates, this is based on the projections by the Office of the Actuary. When you compared them to rates of increase in the past, we are seeing a slowdown in the rate of increase in health care costs. The 15 percent is intended to reflect the estimates that the actuary has made of the projected rate of increase.

Mr. GREENWOOD. Let me interrupt you for one second there because that is a very important point.

Ms. FEDER. Go right ahead.

Mr. GREENWOOD. That 7½ percent per year is obviously a little bit different because of the compounding, but it is pretty close. Are you telling us that the rate of increase in health care costs over the past 12 months, for instance, has been about 7½ percent?

Ms. FEDER. I cannot speak to this precise number, so I do not want to answer it. What I can tell you is that the estimate was made by the Office of the Actuary, and despite whatever difficulty you have had I will get you this letter for the record that clarifies.

In terms of the timing, there may be a technical—it sounds as though there is some misunderstanding with respect to the previous estimates. I believe we have estimated what is in the bill, that that is what the Actuary's Office has estimated, and so I am not distressed about that.

And again, our 15 percent constraint is based on our estimates—his estimates of projected expenditures. And so we will get back to address the specific point.

Mr. GREENWOOD. My time is up. I would appreciate it if, when you provide us with this information you also would give us information about why the 15 percent originally applied to 3 years and then was reduced to 2 years. That is a very, very significant difference.

Mr. CLAXTON. As I understand it, the original drafters thought that we had estimated 3 years when we had only used 2 years, and so it was just a technical error.

Mr. GREENWOOD. There was an error in the first draft?

Mr. CLAXTON. Yes. We will clarify that.

Mr. GREENWOOD. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Greenwood.

Now, for our second round. One of our next panelists, Dr. Dan Fishbein, will argue on behalf of the New York Life Insurance Company that the President's proposal will knock fee-for-service

plans and preferred provider organizations into a death spiral. He reasons that plans offering a wider choice of physicians will attract a higher proportion of people with medical problems because those are the people who most value choice of provider.

Over time, he contends, the wider choice plans will lose healthy members while retaining unhealthy members, requiring those plans to increase premiums further and further beyond those of restricted network plans, eventually making the fee-for-service and PPO plans unaffordable except for the very wealthy.

The President's proposal requires both regional health alliances and corporate alliances to offer fee-for-service plans, so obviously you assume that they will be viable. Yet, Dr. Fishbein believes that it will become unaffordable.

What is your response to his argument?

Ms. FEDER. Mr. Chairman, he is raising the concern that several members have raised with respect to the issues related to risk selection, and I would just repeat very briefly that we require all plans, including the HMO's to provide the guaranteed benefit package, to contract with academic health centers or at States' discretion centers of excellence, to provide appropriate referrals and appropriate services, and we are requiring all plans to provide quality of care and creating a market system in which people will be able to choose in that arrangement. So we don't think the incentives are as strong as he indicated.

Furthermore, with respect to risk selection, we have the set of protections that Mr. Claxton has laid out, reinsurance and other mechanisms to protect against adverse selection. And finally, fee-for-service plans, as I indicated earlier, will be operating in a new environment with new tools both to operate under fee schedules with negotiated rates and to identify those practitioners that are inappropriately providing care in order to remain affordable.

Mr. WAXMAN. You testified that the President's bill contains a short-term and a long-term strategy for protecting health plans from adverse selection by higher cost enrollees. In the short term, you propose mandatory reinsurance and health status adjustment. In the long term, you expect that the National Health Board will develop more sophisticated risk adjusters.

We are going to hear later this morning from witnesses who are not so confident in our ability to adjust risk. Stan Jones will testify that "at present we do not know how to ameliorate risk selection or adjust premiums for it is efficient to prevent it from destroying competition based on cost containment and quality."

He goes on to lay out a number of strategies that insurers can, and in sheer self-defense will, use to obtain favorable risk selection under even the reforms in the President's bill. These include avoiding the use of physicians who are known in their communities to be skilled at treating the sickest and toughest cases because they may bring their patients along with them into the plan.

Is he wrong? Or do we have a serious problem here? Or do you agree with Alice Rosenblatt, representing the American Academy of Actuaries, who will tell us that a workable solution can be found by April 1, 1995?

Mr. CLAXTON. Let me—as I discussed a little bit earlier, we have done a number of things to try and address the risk selection by

health insurers and to protect insurers from adverse selection by consumers. It is an integrated strategy. We think we have a number of first steps that are appropriate, including reinsurance to protect against the adverse selection that was mentioned, and the disenrollment surveys, the quality system to deal with the not contracting with providers kind of problem.

This is going to be something that gets better over time. But quite frankly, the alternative is to say we are not going to have universal coverage, so these people get left out of the system, or we are going to have universal coverage but people who are higher risk can't have choice and their fellow employees can't have choice, or that we are going to have risk rating. And we believe what we have is a better alternative because it is based on sound principles. We think it is good enough in the short run and it will get better, and the alternatives are unacceptable.

Mr. WAXMAN. Thank you.

Mr. Bliley?

Mr. BLILEY. Thank you, Mr. Chairman.

Ms. Feder, could you please turn to page 185 of the bill, lines 1 through 12? Let me tell you what I think this provision means. Then you can tell me the administration's intent behind this provision.

This provision seems to say that AFDC and SSI beneficiaries are only responsible for 20 percent of the applicable copayments for all services except emergency services. Lines 14 through 20 go on to say that the regional alliance shall pay the health plan for the cost sharing reductions other than the reductions just described. In other words, the plans will be responsible for 80 percent of the applicable copayments for AFDC and SSI beneficiaries.

Is this the way you understand this provision? What impact do you anticipate that paying the bulk of the required cost sharing will have on health plans? How will this impact their solvency? And, in reality, doesn't this provision statutorily impose cost shifting on all other payers?

Ms. FEDER. The provision, Mr. Bliley, has to do with the specific additional reduction in cost sharing for AFDC and SSI recipients, so that they would pay, instead of the \$10 per visit that is in the low cost sharing plan, they would only be expected to pay \$2 per plan, and that there is not an additional payment to the plan to offset that differential.

The reason that we do not believe it creates a problem for the plan is because the premium contribution that is being made on behalf of AFDC And SSI beneficiaries are based on existing Medicaid per capita payments trended forward, takes the full payment into account. It is included in that premium estimate, and so we believe they have already essentially been paid in that circumstance.

Mr. BLILEY. I see. You also testified in your opening statement that if the plans are running overbudget that steps will be commenced to force them underbudget.

Won't that lead to rationing? I mean, how will you achieve this forced compliance?

Ms. FEDER. It is a prospective adjustment to the premium and it works automatically, and the way in which it is achieved is that plans that—it is not that they were running overbudget. It is that

their premiums led the alliance to have an average premium that exceeded the cap. And what the bill specifies is that premiums will be reduced in plans that exceed, along with payments to providers in those plans. So, there is a mechanism that not only reduces the premiums but reduces the pay-outs consistent with the reductions that are needed to keep the plan at an affordable level.

Mr. BLILEY. OK. Well, if you reduce the payments to providers, how do you guarantee that the providers will be there to provide the service?

Ms. FEDER. I think that what we are doing, there is a change in the way the marketplace is working. We really are holding providers accountable for delivering quality services at affordable costs. You, I know, are well aware of the inefficiencies we have in the current system.

Over the last several months we have heard from numerous practitioners, whether in hospitals, individual doctors, about the inefficiencies in the system. We believe that with a new set of incentives with information for providers as well as for consumers on what is appropriate service and how to deliver care effectively that we can make dramatic changes in the costs in the marketplace, and we expect we will do so.

Mr. BLILEY. And you don't think that providers won't close up or just stop taking patients?

Ms. FEDER. No, I don't expect that they will. I think that they will be, as I said, operating under new terms and that the resources are adequate to continue to not only provide the quality of care that we have today but continue to improve quality through more efficient delivery of service, and I do not expect that problem.

Mr. BLILEY. Thank you.

Mr. WAXMAN. Thank you, Mr. Bliley.

Mr. Brown?

Mr. BROWN. Thank you, Mr. Chairman.

One of the factors contributing, obviously, to high cost in health care has been third-party payers. I talked to a veterinarian in my district sometime ago who told me that it costs 40 times—a hip replacement in a dog costs one-fortieth—is one-fortieth the cost of a hip replacement in a human, and one of the—there are, obviously, a lot of reasons for that, but one of the reasons is people when they walk out of a veterinarian's office obviously pay out of their pocket, although apparently dog insurance is available, few people still have it, thankfully.

To bring in kind of incentives like that, some have proposed a medical savings account where the employees, you know, would pay for their preventive and other health care visits up to \$2,000 or some other high deductible, at which point the insurance would kick in.

Are you considering anything like that to sort of inject that sort of consumer discipline into our health care system that way?

Ms. FEDER. Well, Mr. Brown, the issue that you raise is clearly a problem because when we have insurance it does reduce our ability to pay or sensitivity to price at the point of service as a control on what the prices are.

But there are two different ways to deal with that issue. One is to reduce the availability of insurance, have these much higher

deductibles that the medical savings accounts assumes, and that puts the burden then on the consumer. But what we know is that the bulk of the cost in the system, as Mr. Hastert was indicating, come when people are sick and when it is physicians who are treating sick people and generating the cost of care. It is not us who determine the most costly service when we are sick. It is the doctors choices that determine what we spend.

And consequently, in order to protect people from unacceptable burdens while still promoting efficiency, what we have got to do is change the incentives under which practitioners operate, not give us higher burdens. That isn't going to do the job. What we need to do is change the incentives of the system, and that is the direction in which we have gone.

Mr. BROWN. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Brown.

Mr. McMillan?

Mr. MCMILLAN. Thank you, Madam Chairman—Mr. Chairman, excuse me. I am getting you confused with the panelist.

Do you have a copy of the bill here? You probably have it in your head.

Ms. FEDER. Yes, we do.

Mr. MCMILLAN. On page 990, section 6002, you get into the issue of the board determination of national per capita baseline premium target, which is somewhat related to the earlier question, I think, from the gentleman from Pennsylvania which had to do with an adjustment period.

But essentially, if I don't oversimplify this, what you are going to try to do is to take total medical care outlays for an expected group of participants in regional health care alliances and divide it by the expected population to come up with a per capita premium target. Now, I know that is an over simplification.

Then that presumably is going to be the rate at which regional alliances will be reimbursed or will be able to—that will fix the price, in effect, on those plans and be the basis upon which a lot of other decisions are made.

There is one part of that that I don't understand because it does deal with two of the big components of Federal expenditures. One is Medicare. They are excluded. And two are current recipients of AFDC or SSI benefits.

On the one hand, Medicare is going to continue as a Federal program, albeit one modified rather dramatically, we are not quite sure how, because there we have been experiencing the same increase in costs at a rate of about 12 percent a year for the past decade, and we don't know quite how that is going to be scored out in that classification. The other is AFDC and SSI, which are under Medicaid.

But, if you go on over to page 994, you make an exception with respect to AFDC and SSI that I really don't understand, which really gets at the issue at what rate are regional alliances going to be reimbursed for people in those categories.

Ms. FEDER. OK, let me—the first, I just wanted to make, it wasn't much of an oversimplification in the system. I just want to clarify some pieces of it.

It is, number one, when we look at per capita spending in the regional alliances, it will take into account any changes needed because of a guarantee of a comprehensive benefit package and adjust for getting everybody insured.

The second piece, the clarification that I need to add is that you remember that this is not fixing premium rates. This is a backup system. So, the actual premiums will be based on the bids to the alliance. This is the underlying or safety net, our backup budget system.

Mr. McMILLAN. What happens, by the way, if they don't get any bids that equal or are below the target?

Ms. FEDER. Well, there is—I think that that goes back to an earlier question as to whether—I believe it was Mr. Brown who was asking me whether people wouldn't bid or wouldn't participate. It may not have been Mr. Brown. I am not sure who it was.

We believe that there is a great opportunity here, an incentive in the marketplace to enroll people, that there is tremendous opportunity to provide care more efficiently, and so we have little doubt that people will bid.

Should there be difficulties we do have a technical mechanism for adjusting those premiums downward.

I am trying to be quick because I used up your time last time.

Mr. McMILLAN. Yes. I wanted you to get to the aspect that you all tried.

Ms. FEDER. I want to, too.

You asked separately about the Medicare and the Medicaid. Medicare, yes, it does remain a separate program at the outset. That is why it is distinguished in the section you referred to. We do have, as you know, a specific set of proposals of policy adjustments to Medicare to slow the rate of increase in that program focusing primarily on provider payments as we are slowing the rate of increase in cost in the rest of the system. We believe that comprehensive approach is critical, so we have the specific mechanisms.

For Medicaid—Medicaid dollars you will remember are being used to pay the premiums for the cash assistance population, AFDC or SSI, and those premiums are subject to the same constraints as the rest of the system. So, in that respect, that is controlled under the same mechanism.

Mr. McMILLAN. Are we then picking up at the Federal level 100 percent of the reimbursement rate, whereas today that is at roughly 50 percent?

Ms. FEDER. What we are doing is the Medicaid, the premium that will be paid for the cash assistance population is based on current per capita Medicaid spending. So we are taking that as it is. And then we come back to the alliance mechanism.

What we do at the alliance level is we blend that per capita payment with a plan's private bid, so where there may have been underpayment on the one side, there is overpayment on the other, and we blend that together in determining what is actually paid out to a health plan.

So, we are not raising what Medicaid pays. We are recognizing there is a differential in the system and blending it and spreading it across all premiums.

Mr. McMILLAN. I think I am out of time. But I would like to ask you, if you would, to provide me or give me directions to how I can determine how disproportionate share payments that we currently have would be blended into that system.

Ms. FEDER. Do you want me to quickly answer or—

Mr. McMILLAN. Go ahead.

Ms. FEDER. The disproportionate share payments are removed from that calculation. The disproportionate share, as you know, is there in order to cover in large part the cost of uncompensated care of those who are not insured. Everybody is insured. Consequently, we don't need those dollars anymore. A portion is retained for—

Mr. McMILLAN. So, then you would expect a State, if they had justifiably incurred disproportionate costs, to serve a section of the population under the existing law. Under the proposed plan, they would be fully reimbursed for that care and therefore not entitled to disproportionate share payments, because they would then flow through on a per capita basis and therefore the need for the program would vanish.

Ms. FEDER. Well, what the issue is, really I would say it is on the provider side. The hospital is going to get paid now for everybody who comes in, and it is everybody the same rate in the plan whether it is a Medicaid beneficiary or someone else. So they are going to get paid the same rate. Everybody is covered. There is payment for everybody. That is why we don't need that.

Mr. McMILLAN. I think that is an ideal way to handle it. However, we both know that a lot of disproportionate share payments have been used to pay for things that don't provide services to the designated population, and that is a problem.

Ms. FEDER. And it is an issue that we continue to explore in terms of the maintenance of effort, which is a separate part of the obligation of States.

Mr. WAXMAN. Thank you, Mr. McMillan.

Mr. Kreidler?

Mr. KREIDLER. Thank you, Mr. Chairman.

Dr. Feder, Mr. Hastert—who will be next in line after me, perhaps he can correct me if I am not raising the same kind of questions that he is—but he raised a question of the fairness to let large employers out of the regional alliances. Washington State, as you well know, has already enacted a plan that has a similar opt-out.

However, it is a little bit tighter. Rather than 5,000 employees nationwide, it has 7,000 in State in order to opt out. So, it is a little bit tighter than the President's reform plan.

But it requires those large firms to pay the same community rated premiums if they opt out in the State of Washington as everyone else that is in the alliance. Wouldn't that spread the risk more fairly across a region, like the Chicago area, as Mr. Hastert suggests, as opposed to what you have in the plan right now, which is, I believe, a 1 percent surcharge if you opt out?

Ms. FEDER. Yes, there are alternative mechanisms. And you are quite right, we are relying on the 1 percent assessment to assure a communitywide contribution. That is an alternative approach that could be considered.

Relative to other comments that have been made, that would reduce the reward to those very large firms from the effective—potentially it might, would—well, maybe it wouldn't reduce it for the management. It wouldn't.

Go ahead, Gary. I want to withdraw that remark.

Mr. CLAXTON. I think the issue that is being wrestled with there is that when you are going to allow large corporations to operate their own alliances and they are going to be multistate, should they be able to operate sort of—how should they be able to set their premiums and should they have to, if there are, let's say, 75 regional health alliances, would they have to have 75 different community rates if they are nationwide, or can they pool more broadly? I think those are the things that you would be balancing if you try to have the same community rate inside and outside corporate alliances.

Mr. KREIDLER. Well, they more or less do that right now with the worker's compensation program. I don't know why it is that much different.

Mr. CLAXTON. It is true in workers comp they are subject to each State's law and they, obviously, don't like that. Again, it is a balancing as to whether or not a corporate alliance who sets up an— a corporation who sets up an alliance can operate as efficiently as it thinks it should be able to. And, you know, you have a valid point.

And there is, you know, disagreement on this one between the various sides. We tried to come in and say, yes, there will be corporate alliances. They are only the largest corporations but we will give them some freedom to operate separate from State laws, as they have under ERISA. We reduced their freedom to some extent, but not completely.

Mr. KREIDLER. Would there be a desire on the part of the administration to see it move to a tighter definition of which large employers can opt out, and then perhaps to make this kind of a shift to regional community rating, or would you prefer to stay with the 1 percent and see how that works?

Ms. FEDER. Well, Mr. Kreidler, I believe that our proposal is out there establishing the balance as we saw it best achieved. But we are happy to continue to work with you as you continue your deliberations.

Mr. KREIDLER. One concern that some large employers have is that they do a very good job of encouraging health prevention through their various programs that they have. I am curious.

Do you see them still finding an incentive to be actively involved in making sure their employees live healthy life-styles and so forth? Or perhaps they haven't been that active in that particular role as they might think. It has been much more trying to prevent costs by essentially making sure that they pay for only their own health expenditures, not those for people who are cost shifting over to their plans and so forth.

Ms. FEDER. Well, I think that some corporations, some businesses have made what are valuable contributions in terms of promoting health of their employees. It is our view that they would continue to have that incentive even if in the regional alliance, because they benefit from having healthy employees who come to work.

Health costs are not the only issue. They need them there to work, so those incentives remain.

Mr. KREIDLER. Very good. Thank you very much.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Kreidler.

Mr. Hastert?

Mr. HASTERT. Thank you, Mr. Chairman.

First of all, I want to say when we talk about disproportionate share payments, I commend you for what you are doing. There is approximately \$90 billion in the system today. I know in the State of Illinois we are paying about \$15,000 for a family of five on Medicaid, average cost. When they get health care, they are getting it in the emergency room, instead of getting primary care.

And I think that movement to take a lot of that money, not all of it obviously, take a good portion of it and redistribute it in a much more effective way is something that has to be done. You are not the only person that does it in your health plan. Other health plans are doing that, also.

But there is one matter I want to clarify. You said AFDC patients and SSI patients are purchasers of health care that fall into those categories. Does the health alliance pick up any of that cost?

Ms. FEDER. No, sir. Essentially the premium—what we have is that the State pays in using the State and Federal dollars, go into—are paid as premiums for the cash assistance recipient.

Mr. HASTERT. So, there is actually a capitated flow of money.

Ms. FEDER. That is exactly correct.

Mr. HASTERT. So, every family or individual, however they would come under SSI—the State, or the Federal Government would pay that health alliance \$1,800 approximately per person?

Ms. FEDER. The payment for the AFDC or SSI recipient is based on the per capita spending for that population in the State. It is not tied to the premium—

Mr. HASTERT. So, it could be probably a higher rate then, right, if there is higher spending for SSI recipients?

Ms. FEDER. The dollar amount—if there is higher utilization for that population, although lower payment rates, the dollar amount may be higher.

Mr. HASTERT. Do you know exactly what that amount would be?

Ms. FEDER. I would have to provide that for you afterwards, because we clearly looked at that when we were putting the estimates together.

Mr. HASTERT. That is one of the areas where we need to see your assumptions.

So, you also talked about an adjustment to premiums if health alliances and individual health care providers were over the caps; is that correct?

Ms. FEDER. An adjustment to premiums.

Mr. HASTERT. So the premium that a company would pay, 7.9 percent by an employer and about 2 percent by the employee, would be reduced down if they were paying into a health alliance?

Ms. FEDER. Let me clarify. The 7.9 percent—

Mr. HASTERT. That is why I am asking the question.

Ms. FEDER. OK. The 7.9 percent you are using in the—it is on average, I believe, about 1.7 percent for individuals. But that is

really—that is a cap. The 7.9 is a cap on employer payments. So, just remember as you think about it, they are paying the premium but no more than 7.9 percent in the regional alliance.

If there are adjustment, downward adjustments to the premiums because plans have exceeded the cap, there is a—essentially it becomes—is a rebate a fair term? Where there is an adjustment to what the employers and individuals in an alliance will pay to bring that into line.

Mr. HASTERT. So, it is a squeeze on the health care providers then. If they are not meeting it, they are going to be penalized. It is a hammer.

Ms. FEDER. It means that essentially the plan and its providers must live within the cap, if it comes to that, if we need that, or within the competitive marketplace, and we are setting up a system in which plans and providers will be held accountable. But we believe it will be through the marketplace and that the cap is a backup mechanism.

Mr. HASTERT. Already there is a lot of cross-subsidy in the system, and in your plan—well, first of all, in the President's budget, I think he squeezes out about \$50 billion in Medicare and about \$7 or \$8 billion in Medicaid, something like that. And then also I think in your plan you squeeze or you carve out another \$128 billion in Medicare dollars that go into the system. Because you are saying these are savings and we are going to squeeze these savings out.

One of the problems in my district that I have seen happen time and time again when I walk through the hospitals and visit people who really conscientiously are providing good care, quality care to patients of all economic levels and stratas, what I hear is that the cross-subsidies that exist in those institutions today, why people in insurance companies and companies that pick up their own insurance costs, and individuals have that have the ability to pay their own hospital costs are paying from 140 to 160 percent of the actual cost that the hospital incurs because there is already a cross-subsidy.

There is a cross-subsidy because there is a gap in Medicare payments from the Federal Government. There is a gap in Medicaid payments from the State. You know, when you start even carving more of that out, my concern is—and I would like to see the documentation on where these savings come from.

I remember Mrs. Clinton sitting where you are sitting and the First Lady telling us, "Well, there is a hospital in Pennsylvania that can give a heart surgery for \$28,000, another that gives it at \$80,000."

I went to Pennsylvania. Well, there were some extenuating circumstances behind some of those operations and not every—I found out not every cardiac bypass is the same as the other, and those count into some of those costs. Maybe there was extravagance in one hospital and not in another.

But when you start to squeeze those savings out of the system, looks like we squeezed a lot of savings, and a part of the problem is cross-subsidies already exist because you can't pay for quality care this way. And I guess the cue word "quality" is something that haunts me all the way through.

You know, I went to Canada and looked at the hospitals, walked through Toronto General Hospital and saw, you know, 10 or 15 people in a ward and being pushed through, and 20 percent of the beds being left for people who were acutely ill, and 80 percent of the beds there for people who were chronically ill. I mean that was kind of a unique rationing system that hospital administrators figured out.

I was in Germany and saw the quality of the hospitals that people have there under that system. I have been in Japan and walked through the wards. It is something that most Americans wouldn't accept today as quality care. And I guess that is the ghost or the haunt or the phantom that tracks us all the way through.

When you start squeezing dollars out of the system and you start to squeeze down the amount of even the money that health care providers have when they are a little bit over the, you know, this budget that you hand them, where is the quality at?

And that is why I want to see where those savings are. We need to have those numbers, those dollars. I mean I can hear a story about a couple hospitals in Pennsylvania, but give us the facts so we know what you are talking about. That is frustrating.

Ms. FEDER. I will say once again, Mr. Hastert, we do expect to give you those. But let me address the specific concerns that you raise.

Number one, quality is critical to us. We have got to not only preserve but continue to promote quality in our health care system. When you talk about going to other countries and looking at their health care systems, they are spending—Canada spends what, 30 to 40 percent less than we do per capita on health care. Germany and Japan are at roughly half our per capita rates. We are not talking about cutting spending to those levels. We are just talking about slowing the rate of increase in our own spending.

So, let us be very clear that we are continuing to preserve and, in fact, are putting more dollars in up front as we get everybody covered in our system.

And that addresses the second concern that you raise with respect to providers and reductions in the rate of growth in Medicare spending. The very major difference that hospitals in this Nation will see when we enact universal coverage is that everybody who comes in that door carries payment with them, and at the same time we slow rates of growth for those who are currently covered under Medicare. And, again, it is only slowing rates of growth.

We are providing them payment for people for whom they do not now get paid. So that many of our most disadvantage hospitals are likely to be in a better position when universal coverage is in place.

Mr. WAXMAN. The gentleman from Oregon, Mr. Wyden?

Mr. WYDEN. Thank you very much.

Dr. Feder, I have really been amazed that some of the forces of the status quo are attacking the administration's point-of-service option, and I and others really fought hard for this and I think you all deserve a lot of credit for it. And it seems to me that one way to really nail this down would be in the enrollment listing materials that are sent out by the alliances, what would you all think about grouping specifically the point-of-service, you know, plans so that the consumer could actually compare those with the fee-for-

service and the closed networks? Then we would be able to show everybody all across this country that consumers were really being given a choice in an understandable way, not buried in some little rider there. Is that something we could work with you all on?

Ms. FEDER. I think absolutely, Mr. Wyden. I mean our interest is in providing the clearest information and choice to consumers that is possible. We are happy to work with you on that.

Mr. WYDEN. We are going to fight this rearguard attack on consumer choice, which is in my view what is going on with those that are going after the point-of-service option, and I appreciate your answer.

The second question I had is in the battle of the charts, and my good friend Tom Bliley—I don't know if the gentleman is here—has in his chart, I guess it is being given out today, on the adjustment for previous excessive rate increases, it says "The hammer will automatically reduce the inflation factor in the next 2 succeeding years for all plans in the alliance." My understanding is that misstates the administration's position.

Doesn't the administration have the flexibility to go after just these high cost kind of plans?

Ms. FEDER. That is correct. Thank you for the correction, Mr. Wyden.

Mr. WYDEN. Already. Well, I appreciate it. I am very fond of the gentleman from Virginia and I think there is no malice here but—

Ms. FEDER. Oh. Wait. Excuse me. I was happily agreeing with you, and I need a correction.

Do you want to do it, Gary? Go ahead.

Mr. CLAXTON. This was a—

Ms. FEDER. We will fight over the microphone. The issue here is that essentially, and I would have to double check the language that you are looking at, but the issue is that when plans exceed the target, it is the high cost plans that are brought down. You are quite right, and that is what I was agreeing with.

There is a separate issue—OK.

Mr. WYDEN. I think that that is a fair statement. I just want the record to be clear that in the administration's proposal there is the flexibility to go after these high cost plans, and it is important that the record show it.

Ms. FEDER. It is an automatic mechanism. It goes after those plans.

Mr. WYDEN. Correct. The only other point that I wanted to make on this round, and we sort of pummeled this on risk selection and risk adjustment. What a lot of us are concerned about is that risk selection is going to be done prospectively by tough savvy insurance companies. You are going to have the Aetnas and the Blues and people who are in the business and are going to be very sophisticated.

Then, on the other hand, risk adjustment will, in effect, be done later by people that the public is going to say, Hey, these are a bunch of bureaucrats and they are a bunch of academicians, and I am just concerned that we ought to do some more work on that. Because if it takes us awhile to try with risk adjustment to undo some of the problems after tough, savvy people have been able to

go at it prospectively, we are going to be causing ourselves some grief that we don't want—you don't want, we don't want, as we try to get the administration's bill passed.

And I think that is what is on the minds of those of us who talk about this risk selection and risk adjustment. It looks like there is an imbalance of power. And, if people in my district say, "Hey, this is Aetna up against an itty-bitty academic health center, they are going to say Aetna is going to run away with this thing and drive the process."

Ms. FEDER. Mr. Wyden, your concern in that area is appropriate and well taken, and it is why, although we believe that we are addressing, as we indicated, a number of concerns that you have that we also need a substantial—need to think about it very carefully, need to continue to invest in research in order to make certain that we address these problems, and we do very much want to work with you on that.

Mr. WAXMAN. Thank you, Mr. Wyden.

I think it is Mr. Greenwood next.

Mr. GREENWOOD. Thank you, Mr. Chairman.

Dr. Feder, I would like to turn to pages 231 and 232. It is the section with regard to the marketing of health care plans. That section appropriately says that the plans are prohibited from distributing marketing materials that contain false and misleading information. That is fine.

It calls for prior approval by the regional alliance of any marketing materials to be distributed by the plan, and then it says under the section "Entire Market," "a health plan offered by a regional alliance may not distribute marketing materials to an area smaller than the entire area served by the plan."

In this age of electronic advertising, I would assume that the plans will want very much to compete for market share and volume. I understand the purpose of this section is to try to reduce cherry-picking and so forth. But it would seem to me that a company would probably rather advertise its product on MTV than, say, reruns of Lawrence Welk.

Ms. FEDER. It seems likely.

Mr. GREENWOOD. Yes. They would probably rather advertise in Sports Illustrated than in Reader's Digest. Is that prohibited by that section?

Mr. CLAXTON. This section gives the alliances some discretion, obviously, in how they do this. The goal—in my past of an insurance regulator we made HMO's advertise their open enrollment and you would sometimes have negotiations as to whether or not they are going to put it in this newspaper or that newspaper, and so I am not sure you can say exactly what is prohibited or not prohibited.

But our tenor, our goal here is to assure that in general they don't send direct marketing just to the affluent areas and not to the poor areas or that they don't just put the billboard in one area and not others. You can't do this perfectly, but you can set a goal and try and do it as well as you can.

Mr. GREENWOOD. I understand what the intentions are, and we also know that the road to hell is paved with good intentions. And I am concerned about, if I am a health plan and I want—you were

thinking, I think the framers of this were thinking in geographical terms and advertising is much more sophisticated than that and they know how to target markets by telephone and by television and radio and other media.

How is a company going—is a company going to have to come in to the alliance every time it plans an advertising campaign and get approval not only for the content but which television shows they advertise on?

Ms. FEDER. Mr. Greenwood, it is clearly not our intent to put unacceptable or untenable burdens on plans, but it is absolutely our commitment that we have prevented misleading advertising—

Mr. GREENWOOD. No, misleading is an entirely subject.

Ms. FEDER. Or selecting. Excuse me. Selecting.

Mr. GREENWOOD. I am talking about targeting a message to an area that is smaller—this bill says that you can't distribute marketing materials—that means advertise—to an area smaller than the entire area served by the plan.

Ms. FEDER. It gets to the concerns that Mr. Wyden was raising a moment ago. That there remains an incentive to plans to be selective. There is no question about it. And what we are looking for is the most effective mechanism for minimizing and reducing the capacity of plans to do that in a workable way, and that is what we believe we have put forward.

Mr. GREENWOOD. Again, I understand the goal. I think that you are going to have—I envision some pretty significant First Amendment issues here. I envision a whole lot of red tape that is going to get in the way of health plans' marketing, and health plans are going to want to market. They are going to want to be able to brag about their customer relations, the kind of service that they provide, in order to attract business. There is less and less that they can use to compete on in the system. But I am afraid of a very chilling effect that can be placed on the health plans with this kind of restriction on how they communicate with their prospective clients.

Ms. FEDER. I disagree with you. I think that essentially to brag about their customer relations they will have every opportunity to do that. All we are concerned about is that they not do it in a way that brags only to people who watch MTV as opposed to Lawrence Welk.

Mr. GREENWOOD. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Greenwood.

We are pleased to have Mr. Sharp with us and I wanted to recognize him, if he wanted to pursue any questions.

Mr. SHARP. Thank you very much, Mr. Chairman.

And Dr. Feder, if you have already answered this we can save it for a private conversation, because I don't want to impose on my colleagues. But one of my essential concerns is how we assure that this monopolistic alliance remains competent and effective in the job that it does, and my impression is that if Congressman Cooper were here he would be arguing why you make them competitive as well by having multiple possible alliances within the same territory that would be in a competitive way.

Can you address that question? Because, I must say, this issue comes up in my own district as people don't really have a very good

understanding yet, but some of them are beginning the sense and fear this monopolistic power that really will not be, which may either operate incompetently so one region or another simply is not well served or that the way the power is distributed on the board will somehow exclude certain and make more favorable certain hospitals vis-a-vis other hospitals.

Ms. FEDER. Well, I think that the key issue here, Mr. Sharp, is that alliances are responsible to the communities whom they represent. They are run by boards of consumers, employers, employees and other consumers. The objective, the whole purpose here is to serve the consumers, and they are expected to accept all the premiums, all the plans whom the State certifies as participating in their alliance, give consumers the full range of choice.

All the incentives are that they be responsive to consumers, and that is the way we have structured it and we believe that that accountability will be there.

Let me just also point out that in Mr. Cooper's bill that there is a single alliance in an area, although he does not require employers to participate. So there are some differences there.

Mr. SHARP. Well, I take that there would be other possible alliances there, therefore one might compare one to another as to how one is effectively working, because a large employer may be an alliance in the area dealing with the local hospital or plan.

Ms. FEDER. But there is not a choice among—

Mr. SHARP. I see. Among them, period.

Ms. FEDER. Yes. If you are a certain size.

Mr. SHARP. I will then stop. But I just raise this. My own doubt about our ability to make it as responsive and accountable as you say. I think we have a terrible time within the current political representative system making it with what we all are very familiar with, elections, making it accountable to a broad base of people, and so I have even greater doubts about our capacity to do it there, if there is a way to get a market discipline into that process. Perhaps there is not.

Ms. FEDER. I think that accountability is a very critical issue, but I am not sure that competition in this respect would achieve it. And what we have spent a great deal of time talking about today are the problems in fragmenting the marketplace if we allow that kind of competition among alliances.

So, I am not sure that its primary purpose or an end result would be to achieve your goals. In fact, it might do more harm than good in terms of the ultimate protection of consumers. But the accountability is a critical issue.

Mr. WAXMAN. Thank you, Mr. Sharp.

Dr. Feder, Mr. Claxton, thank you very much for your participation at this hearing. Obviously, you can tell that this particular subject has drawn a lot of interest on our part. So, we will look forward to visiting with you further on this matter.

Ms. FEDER. Thank you, Mr. Chairman.

Mr. WAXMAN. Our first panel of witnesses today includes representatives from different types of health plans currently operating in various markets around the country.

Anna Lore is the Health Plan Manager for the Kaiser Foundation Health Plan of North Carolina.

Dr. Neil Schlackman is the medical director of U.S. Healthcare in Blue Bell, Pa.

Elliot Segal is the President of the National Capital Preferred Provider Organization in Bethesda, Md.

Dr. Dan Fishbein is the Vice President of the Group Department of New York Life, and he is testifying today on behalf of the Health Insurance Association of America.

Without objection, your prepared statements will be included in the record in their entirety. What we would like to ask each of you to do is to limit your presentation to us to no more than 5 minutes.

Ms. Lore, why don't we start with you.

STATEMENTS OF ANNA M. LORE, HEALTH PLAN MANAGER, ON BEHALF OF KAISER PERMANENTE CARE PROGRAM; NEIL SCHLACKMAN, MEDICAL DIRECTOR, U.S. HEALTHCARE, INC.; ELLIOT A. SEGAL, PRESIDENT, NATIONAL CAPITAL PREFERRED PROVIDER ORGANIZATION; AND DAN FISHBEIN, VICE PRESIDENT, NEW YORK LIFE INSURANCE CO., ALSO ON BEHALF OF HEALTH INSURANCE ASSOCIATION OF AMERICA

Ms. LORE. Thank you, and it is still good morning, Mr. Waxman, and other members of the committee. I am Anna Lore, Health Plan Manager for the Kaiser Foundation Health Plan of North Carolina, and I am here today representing the Kaiser Permanente Medical Care Program.

Kaiser Permanente is a prepaid group practice program that provides comprehensive benefits to over 6½ million people in 16 States and here in the District of Columbia. We welcome the opportunity to provide our views on the impact of the Health Security Act on Kaiser Permanente.

There are a number of very positive features in this Act which we believe would contribute significantly to the health and financial security of the American people and the quality and efficiency of the Nation's health care system.

We believe Kaiser Permanente could compete effectively in a reformed health system with these features. They include universal coverage, choice of health plan by employees in alliances, alliances which are exclusive rather than voluntary or competing, the requirement that all qualified health plans be offered through alliances, report cards to measure the quality of care and service provided by the health plans, and the satisfaction of their members, a national defined comprehensive benefit package, elimination of medical underwriting and preexisting condition limits, community rating within regional alliances, and equal dollar contribution by employers.

There are other features of the Act which cause us concern and we have recommendations to remedy them. They include the following six features:

First, point-of-service, or POS. The administration proposal, as you heard, mandates the offering of a POS option by each HMO and establishes a POS benefit which has lower cost sharing than the high cost plan—the high cost sharing plan.

This benefit design is absolutely inconsistent with current POS products and the purpose of POS, which is to provide a transition into the basic HMO plan. It would make HMO's substantial indem-

nity carriers, increase their costs, and could impair their ability to be offered. The POS option should be optional and the POS design should include cost sharing that provides an incentive to use HMO providers and that is higher than the indemnity option.

Second, essential providers. The administration proposal would require health plans to have what is in effect a POS or any willing provider requirement for designated community providers under the basic HMO plan. This requirement could create major difficulties for our organization and other health plans. We would become indemnity insurers for these providers and would have no ability to oversee their cost or their quality. We recognize that many essential providers are important health care resources and that the world under health care reform would be significantly different for these providers.

However, this requirement does not provide for a realistic transition. There should be a genuine transitional provision which would include incentives for health plans to contract with essential providers but also for these essential providers to provide high quality, cost effective care. We have created a work group to study this issue and will provide more specific recommendations to the subcommittee.

Third, regional alliances and the single open enrollment period. Most alliances will be new organizations. Their proposed size can be expected to result in major difficulties for consumers and health plans because of the millions of transactions which must occur during startup. The regional alliances should be limited to those who need large group purchasing arrangements, individuals and groups of up to 200 employees. And because the single open enrollment period will be difficult because of the major enrollment shifts that may occur, open enrollment should be staggered on a monthly basis.

Fourth, premium caps. There is a significant possibility that many health plans, including a number of Kaiser Permanente regions, will be unable to keep their premiums below the required caps. This could occur because the phase-in period is too short and the CPI target could be unattainable.

The pressure of new technologies will continue and newly covered members may have pent up unmet service needs. Kaiser Permanente may have to reduce its capital generation for growth and limit our investments in outcomes research, guidelines development and information systems. This would handicap our cost containment efforts.

Premium caps should not apply in areas where well-developed health plans are ready to compete on the basis of cost and quality. At most there should be targets and backup authority. Targets or caps should start with the existing relationship between health care increases and the CPI, be phased in over at least 5 years, and has as a target CPI plus an amount for demographics and technology. Also, an effective technology assessment program should be developed at the national level to both—directed to both current and new technology.

Would you like me to go ahead and cut it short, then?

There are other positive provisions in this Act and others that raise concerns.

Mr. WAXMAN. Let me suggest—I would like you to conclude. We will have this complete statement in the record.

Ms. LORE. Thank you very much. I thank you and I would be pleased to answer any questions you have.

Mr. WAXMAN. Thank you for your testimony.

[Testimony resumes on p. 523.]

[The prepared statement of Ms. Lore follows:]

TESTIMONY OF KAISER FOUNDATION HEALTH PLAN, INC.

Before the Subcommittee on Health and the Environment
House Energy and Commerce Committee

December 9, 1993

I. INTRODUCTION

Mr. Chairman and Members of the Subcommittee. I am Anna Lore, Health Plan Manager for Kaiser Foundation Health Plan of North Carolina. I am representing the Kaiser Permanente Medical Care Program ("Kaiser Permanente"). Kaiser Permanente is a prepaid group practice program which serves over 6.5 million voluntarily enrolled members in sixteen states (California, Oregon, Washington, Hawaii, Colorado, Ohio, Texas, Maryland, Virginia, Connecticut, New York, Massachusetts, North Carolina, Georgia, Kansas, and Missouri) and the District of Columbia. It is the largest private health care program in the United States with over 90,000 employees and over 9,000 full-time equivalent contracting physicians.

Kaiser Permanente provides services in 12 operating Regions. In each Region, Kaiser Permanente is conducted by three separate organizations: Kaiser Foundation Health Plan, Inc., or one of its subsidiary Health Plans, each of which is a federally qualified health maintenance organization ("HMO"); Kaiser Foundation Hospitals ("Hospitals"); and one of 12 Permanente Medical Groups ("Medical Groups"), each of which is an independent multi-specialty group of physicians.

Kaiser Permanente accepts the responsibility of organizing and providing health care on a prepaid group practice basis. People who enroll in Kaiser Permanente receive a full range of prepaid health care services.

We welcome the opportunity to describe how Kaiser Permanente would be affected if the Administration's health reform bill, the Health Security Act, were enacted. We have summarized some of the features of the bill which we believe would have a positive impact and some of those features that cause us concern. We support the positive features noted and we propose modifications to the features that raise concerns.

II. POSITIVE FEATURES IN THE ADMINISTRATION'S BILL

Universal Coverage

Providing universal coverage will improve the health of 38 million uninsured Americans, by improving their access to preventive and other necessary health care services, and will provide financial security for the American people.

Universal coverage will enable many persons who currently do not have access to Kaiser Permanente to enroll in our Plan, and will promote the growth of cost-effective Health Plans and the more efficient use of health care resources. It will reduce cost shifting and will thereby contribute to a more equitable financing system and more equitable competition among Health Plans.

We also support the provisions in the Health Security Act which recognize the capacity limits of Health Plans that organize and deliver health care services and permit them to accommodate to new enrollment on a planned, sustainable basis that enables them to maintain appropriate access to services.

Employee Choice of Health Plan through Alliances

The Health Security Act would allow individuals within Alliances to choose their own Health Plan. This opportunity for choice is highly valued by most Americans and we support it.

Currently, most Americans are not given a broad choice of Health Plans. Offering one or a limited number of Health Plans deprives individuals and society of the benefits that can result from competition based on price and quality, as well as access to different delivery system arrangements. Under current health benefits arrangements for smaller firms, the actuarial problem of splitting small groups among Health Plans results in a choice of Health Plan at the employer level, but usually no choice for individual employees and their families. The Health Plan chosen by the employer must be acceptable to all members of the group and the absence of choice at the individual level reduces choice for persons who may wish to join another Health Plan.

Many persons who are members of small groups have not had an opportunity to select Kaiser Permanente because of this problem. Pooling small businesses into Regional Alliances and providing that choice of Health Plan be made at the employee level will increase the availability of Kaiser Permanente and other HMOs to employees of small groups. We support this important feature of the Administration plan.

Exclusive Alliances

The Administration's proposal would establish one Regional Alliance for each geographic area through which health benefits coverage would be provided for all firms below a certain size. While we have concerns noted below about the size of the firms that would be included in the Alliances and about some Alliance responsibilities, we support the position of the Administration that Alliances should be exclusive for some segments of the market and there should be one Alliance per area. We do not favor voluntary or competing Alliances for any market segment.

If Alliances are voluntary, the benefits of employee choice of Health Plan noted above will not accrue to the employees of small businesses that are outside of the Alliances. Many employees will be deprived of the opportunity to make the selections they wish. The presence of a market outside of the Alliance would also lead to selection bias against the Alliance and its eventual failure. Participating in markets both inside and outside of Alliances would be administratively burdensome and it would be more difficult to effectively monitor and establish risk adjustment mechanisms for multiple markets.

Competing Alliances within a geographic area would add administrative costs and complexity to market monitoring and risk adjustment functions. Competition should occur among Health Plans rather than Alliances, which should be administrative entities.

Offering All Qualified Health Plans Through Alliances

We support the position that all Health Plans which meet standards of quality, accessibility of service and financial solvency be offered by an Alliance. This provides the broadest choice of plans to consumers. It also is essential to the viability of Health Plans with established delivery systems such as group and staff model HMOs. Alliances will constitute a large portion of the market in an area. A model in which only a limited number of Health Plans are offered in any given year based on price, would place the Alliance in the role of too powerful a purchaser and would lead to enormous instability for Health Plans with established delivery systems. Group and staff model HMOs can compete for individual enrollees within an Alliance on the basis of price and quality. They cannot operate under a system in which they can be excluded from participation in an Alliance in any given year on the basis of price and lose substantially all their enrollment. The Health Security Act adheres to this view; except that allowing exclusion of Health Plans with premiums in excess of 20 percent above the weighted average premium in an Alliance is inconsistent with it.

"Report Cards" for Health Plans

A system of comparable performance measures for Health Plans is an important component of the Administration's program. We support the development of a core data set to provide comparable information on various aspects of the accessibility and quality of care provided by Health Plans and on member satisfaction. The development and use of this data is necessary to assure that Health Plans compete on the basis of quality, not just price. Purchasers and consumers must have access to a core data set with which to assess Health Plan performance.

Kaiser Permanente has been among the leaders within the industry in working to develop such a data set through the National Committee on Quality Assurance and other organizations. Our major internal task is to develop the systems to provide the necessary information. We are making progress in that regard. We believe we would compete effectively in a world in which quality is documented and publicized.

National Defined Comprehensive Benefit Package

The Health Security Act would provide a national defined comprehensive benefit package to all Americans. Such a benefit package would provide equity for the public and protection from economic hardship and would promote effective health care treatment. It also would reduce administrative burdens on multi-state purchasers and Health Plans. Comprehensive benefits are consistent with the benefit plans offered by Kaiser Permanente and other federally qualified HMOs.

Most health benefits coverage sold today, other than by HMOs, contains significant benefit exclusions and cost sharing obligations. These gaps in coverage can result in severe economic hardship and barriers to access to health care. They also can result in more costly and less effective treatment because health care providers and patients tend to seek treatment that is covered by the plan, even if it is more costly.

A single defined benefit package promotes choice and competition among Health Plans on the basis of price, quality of care and availability of service which is desirable. A national benefit package provides equity for the public and important administrative benefits for multi-state businesses and Health Plans which face a variety of state requirements.

Elimination of Medical Underwriting and Preexisting Condition Limitations

Health benefits should be available to all regardless of their medical condition, age or occupation. The Health Security Act would assure this by eliminating medical underwriting and preexisting condition limitations. These practices have the effect of limiting health benefits coverage and placing a greater burden on those who are sick or at highest risk of illness. They also focus the efforts of Health Plans on avoiding the enrollment of higher risk individuals rather than on providing cost-effective coverage to all types of people.

Kaiser Permanente does not impose preexisting condition limitations and does not use medical underwriting in any of its group coverages. Elimination of preexisting condition limitations and medical underwriting would promote competition

among Health Plans based on price and quality of care and service rather than avoidance of risk.

Requirement to Community Rate Within Alliances

The purpose of health insurance should be to spread the cost of coverage broadly so that people do not bear high costs at the time they are ill. Community rating is a socially desirable method of achieving that objective. It protects persons who are at higher risk of illness from being priced out of the market for health coverage. Community rating also is more simple and less costly to administer than other rating systems and it is more consistent with the requirement that group and staff model HMOs have for predictable revenues. Community rating encourages Health Plans to compete on the basis of efficiency and quality rather than avoiding or predicting risk. Kaiser Permanente would welcome a return to community rating. We support the requirement to community rate within the Regional Alliances.

We also support the provisions in the Health Security Act which would allow Health Plans to adjust their rates when offered to Corporate Alliances in order to respond to the rates of self-insured plans. This is consistent with the adjusted community rating provisions of the Federal HMO Act.

Equal Dollar Contributions by Employers

The Health Security Act requires that employer contributions be set at 80 percent of the weighted average premium of Health Plans within an Alliance although they can exceed this amount. We support the concept of a fixed dollar contribution which will be an incentive for individuals to choose a cost-effective Health Plan. Such a consumer driven system will enhance incentives for superior Health Plan performance.

III. CONCERNS

Point of Service Design

If the point of service (POS) design in the Health Security Act remains as we understand it, Kaiser Permanente and other HMOs could see a significant increase in the portion of their covered benefits that would be provided on a fee-for-service, indemnity basis. This is because the POS design in the proposal is more comprehensive than most, if not all such products in the market today. It does not contain a deductible. It covers all services. It does not allow any cost sharing for some services and it would have coinsurance of only 20% unless the National Health Board increases this percentage. HMOs could not apply their standards for quality and utilization to these services and continuity of care could be impaired.

If the cost sharing is not increased, the POS option could be more attractive than the high cost sharing plans. Persons who prefer fee-for-service indemnity coverage are likely to select a point-of-service HMO that has a premium lower than the premiums of the high cost sharing plans. This could occur even though these enrollees do not intend to use the HMO's providers. These enrollees would be expected to select the lowest cost plan.

Kaiser Permanente strives to be the lowest total cost Health Plan in its service areas and to offer superior health care. This could be a basis for Kaiser Permanente offering a POS option with a low premium. However, to do so without adequate incentives for members to use our services would result in our enrolling large numbers of members who join solely to obtain low cost indemnity benefits. Because Kaiser Permanente could not effectively apply its cost and quality management skills to these indemnity benefits, its costs could soar. This could potentially price our POS option out of the market. Furthermore, it could produce a premium that exceeds the premium cap which would force us to lower our price and lose money or be excluded from the Regional Alliance. (It is not clear whether we would be allowed to remain in the Regional Alliance with our traditional HMO benefits package.)

In order to protect ourselves against this scenario, we would probably want to price our point of service option above the indemnity plans. (We might not be successful because we would not know in advance what their premiums would be.) If we were successful, we would have protected ourselves against being swamped by those seeking low cost indemnity coverage, but many persons would not elect our Plan because of our high premium.

The objective of having a POS option is to provide persons who are not familiar with HMOs the opportunity to try one while having the security of coverage if they wish to go to a non-HMO provider. Many people want to join HMOs under these terms and will eventually choose to obtain their care from HMO providers.

Point of Service Mandate

The requirement to offer a POS option would compound the problems presented by the benefit design. It would make the guess about the price for the option a very big gamble in the first year of operation. Even if the POS plan design were appropriate, Kaiser Permanente would face great uncertainty in setting the correct price and managing the costs of the option.

RECOMMENDATIONS

1. Offering a POS option should be optional for HMOs. We assume that many HMOs would offer such an option.

2. If a single POS design is desired, it should meet the following criteria:

a. The cost sharing for out of plan use should be high enough to provide an incentive for members to use plan providers.

b. The cost sharing for out of plan use should be significantly higher than the cost sharing for the high cost sharing plan so that people do not use it as a substitute for the high cost sharing plan.

c. The POS cost sharing for emergency care in the Health Security Act should be modified. Emergency services do not involve discretionary use and should be covered under the low cost sharing benefit schedule.

Basic HMO Coverage

The provisions of the Health Security Act could be construed to prohibit HMOs from offering their basic coverages without a POS option to existing and prospective members. This would significantly increase the costs of approximately 40 million HMO members now covered by basic HMO coverage and many others who would want to join HMOs as they currently operate.

It is essential that Kaiser Permanente and other HMOs be permitted to offer basic HMO coverage. To do otherwise would eliminate the choice that offers the best opportunity for quality and cost control and would deprive millions of HMO members of their current choices.

RECOMMENDATION

1. Clarify the benefit and POS provisions in the Act to assure that HMOs are allowed to offer a basic HMO plan and a POS option, but are not required to offer either.

Essential Providers Requirement

This requirement constitutes, in effect, either a POS benefit for providers designated in the legislation or by the Secretary or an "any willing provider" requirement for these providers. However, unlike the POS option, the only cost sharing that would be allowed would be the copayments under the low cost sharing schedule.

This requirement could create major difficulties for our organization and other Health Plans. We would become indemnity insurers for these providers and would have no ability to oversee their quality or control their costs.

We recognize that many "essential providers" are important health care resources for those who are currently uninsured or have inadequate access. We also recognize that the world as envisioned by the Health Security Act would be significantly different for these providers. However, this requirement does not provide for a realistic transition. It extends the status quo for five years and then either drops these providers or a further extension will be provided.

RECOMMENDATION

1. Amend this provision to provide for a genuine transitional provision that would provide incentives for Health Plans to contract with "essential providers" and for these providers to provide high quality, cost effective care. Such a provision would need to be flexible to account for the different circumstances of "essential providers" and Health Plans such as group practice HMOs and their communities.

Kaiser Permanente has created a work group to study this issue and will provide more specific recommendations to the Subcommittee next year.

Regional Alliance Size and Single Open Enrollment Period

Under the Health Security Act, Regional Alliances would include almost all persons in the area except Medicare beneficiaries, federal employees and employees of some large businesses. Regional Alliances would be new organizations, and their start up could be chaotic because of the large number of transactions that would occur as millions of people select among dozens of Plans. Information needed by enrollees may be delayed and Health Plans may not know who their members are in a timely manner and may not receive payment for many members for months.

This would create service problems for members and financial problems for some of our Regions. There could be even more serious problems for HMOs that are thinly capitalized. A number of them might fail and Kaiser Permanente and other HMOs would be required to raise their prices in order to pay the assessments required by the proposal. (See discussion of guaranty fund below.)

In addition, because of the single annual open enrollment period with many people newly covered and many newly eligible for all Health Plans in the Health Alliance, there could be large shifts in membership that we could not forecast. Some HMOs may have significantly higher growth than forecast while others could have unforecasted losses.

RECOMMENDATIONS

1. Limit initial enrollment in Regional Alliances to all individuals and all groups with no more than 200 employees. This is the segment of the market that is most in need of large group purchasing capability. Alliances of this size would still contain enough people to be viable purchasing units and would be more manageable.

2. Establish monthly open enrollment procedures so that approximately 1/12th of the population covered by a Regional Alliance has a choice of Health Plans each month.

Premium Caps

There is a significant possibility that despite their best efforts, most Health Plans, including a number of Kaiser Permanente Regions, would be unable to keep their premiums below the cap required by the Regional Alliances. This could occur because the phase-in period to lower overall spending is too short and the CPI increase target could be unattainable. The cost pressures of new technologies are likely to continue unabated because the technology assessment process established under the proposal is unclear and is likely to take a considerable time to get started. In addition, some newly covered members can be expected to have significant service deficits that need to be met in the first months of enrollment.

Kaiser Permanente could be forced to significantly reduce its capital generation because the premiums it would be allowed to charge under the cap could provide little or no margin. This would significantly reduce capital for growth and we would have to use the membership capacity limitation provision on a regular basis. In addition, we would have only limited amounts to invest in outcomes research, guideline development and information systems. This lower investment would handicap our cost containment efforts.

RECOMMENDATIONS

1. Do not require premium caps in areas with well developed Health Plans that are ready to compete based on cost and quality. At the most, establish targets and backup authority in case the targets are not met. Premium caps may be appropriate in areas without HMOs and for fee-for-service indemnity plans.

2. If there are targets or caps, they should start with the existing relationship between health care cost increases and the CPI, be phased-in over at least a five year period and have as a target the growth in the CPI plus an amount for demographic changes and for reasonable growth in technology.

3. If there are to be premium controls, the Health Security Act which uses a cap under which Health Plans may compete on the basis of premium costs is much better than imposing percentage increase limits on each Health Plan or attempting to regulate Health Plan rates. However, Health Plans whose premiums are below the caps should not be required to lower their premiums in order to help meet the Regional Alliance's goal. This would unfairly penalize those Plans that have done the best job of containing costs.

4. Develop an effective technology assessment program at the national level directed at current and new technology and do not impose premium caps or targets that do not include a provision for increased costs because of new technology until the program is fully implemented.

State Flexibility and the Single Payer Option

Kaiser Permanente operates in 16 states and the District of Columbia. In the Northwest (Oregon and Washington), Kansas City (Kansas and Missouri), Mid-Atlantic States (the District of Columbia, Maryland and Virginia), and the Northeast (Connecticut, Massachusetts and New York) our operating Regions are in more than one state.

Because of the amount of flexibility provided the states, these Regions may be required to meet significantly different standards in their states. They would participate in Regional Alliances that do not cross state lines and have different policies. Some Regions may be under managed competition in one state and a single payer option in another. All of this would greatly increase our administrative complexity and costs.

RECOMMENDATIONS

1. Create a truly national reform with uniform national standards for Health Plans and Regional and Corporate Alliances.

2. Allow Regional Alliances to encompass major metropolitan areas even though they cross state lines and require states with such areas to either develop an interstate Alliance or agree on common practices for interstate metropolitan areas.

Single Payer Option and Group Practice HMOs

The proposal could result in members of Kaiser Permanente and other group and staff model HMOs losing the current benefits of their membership. It provides the option of having a single payer system for the entire state or for a Regional Alliance. However, there is no requirement that group and staff HMOs be offered and paid on a capitation basis. The cost savings they

generate would accrue to the state and not their members. This was the case with Medicare before the HMO risk contracting provision was enacted. Today over one million Medicare beneficiaries are HMO risk contract members and the number is growing.

RECOMMENDATION

1. The single payer option should provide that all group practice and staff model HMOs would be offered to all individuals in the state or Regional Alliance and that they would be paid on a capitated basis.

HMOs in Corporate Alliances

Members of Corporate Alliances should have the opportunity to join HMOs. The proposal requires that Corporate Alliances offer employees three plans, but only a fee-for-service plan is required. The irony is that employees of smaller groups will have a wide choice of plans including all HMOs in an area while employees of large groups could have no HMO choices at all.

RECOMMENDATION

1. The proposal should be amended to require Corporate Alliances to offer at least one group or staff model HMO and one IPA or network model HMO if they are available in the area.

Guaranty Funds

As indicated above, there is a strong possibility that a number of Health Plans will fail. This is true in any competitive environment, but as indicated, would be exacerbated by the large amount of uncertainty and complexity the proposal will introduce.

The proposal protects the consumer in case of a Health Plan's failure and inability to pay claims. However, it goes too far. It would also protect creditors and contracting providers who have agreed not to bill the member if they are not paid by the Health Plan. This would result in higher costs than are necessary to protect the member and higher assessments against the remaining Health Plans which would be passed on to their members in higher premiums.

RECOMMENDATIONS

1. HMOs should not be subject to the proposed guaranty funds.

2. HMOs should be subject to substantial capital, reserve and other solvency requirements such as those developed by the National Association of Insurance Commissioners.

3. There should be a national fund to protect members of HMOs that fail. The fund should not include protection for creditors or contracting providers that have agreed not to bill members in the case of a Health Plan's insolvency. It should only pay unsatisfied claims of non-contracting providers.

Pricing of Outpatient Prescription Drugs

The Health Security Act contains several provisions that have the potential of severely affecting the pricing of outpatient prescription drugs for hospitals, their buying groups, health maintenance organizations and other prudent purchasers.

As a condition of participation in the Medicare program, pharmaceutical manufacturers would be required to pay rebates to the government for each unit of a single source or innovator multiple source drug purchased by Medicare beneficiaries in the amount of the greater of: (1) 17% of the average manufacturer price (AMP) or (2) the difference between the AMP and the weighted average of all discounted prices offered to non-retail buyers.

Like the Medicaid rebate law, an additional rebate would be paid on a drug-by-drug basis by manufacturers who raise their prices faster than the general rate of inflation.

The existing Medicaid rebate program creates incentives for manufacturers to discontinue or modify discounts to prudent purchasers by subjecting all Medicaid sales to the same level of discount as the deepest discount a manufacturer offers. Not only is the Medicare Part B outpatient drug market roughly three times the Medicaid market, but the weighted average formula would encourage manufacturers to reassess all their discounts, not just their deepest discounts.

The Administration's plan provides that a drug manufacturer must offer the same price to each wholesaler, retailer or group of wholesalers or retailers purchasing the prescription drugs on substantially the same terms as any other purchaser. The terms listed in the bill induce "prompt payment, cash payment, volume purchase, single-site delivery, the use of formularies by purchasers, and any other terms effectively reducing manufacturers costs." Clearly, basing discounts solely on different trade classes would be unacceptable under the plan. Earned discounts could be difficult to quantify and could lead to manufacturers adopting unitary prices.

If Health Plans are to keep their premiums within a Health Alliance budget, Health Plans must be able to reduce the costs of goods and services used by Health Plans. Through a variety of drug cost containment tools, Kaiser Permanente has been successful in moderating pharmaceutical costs and reducing Health Plan member drug costs. Kaiser Permanente believes these drug related provisions will erode the Program's ability to control drug costs.

RECOMMENDATIONS

1. Amend the proposed Medicare rebate provision to be a flat percentage of manufacturers' prices.
2. Amend the provisions relating to allowable discounts to authorized additional bases for discounts. We would be pleased to work with the Subcommittee on this issue.

CONCLUSION

Thank you for the opportunity to present our views. We have tried to discuss the key provisions of the proposal as they would impact on Kaiser Permanente. There are other positive provisions and other provisions that raise concerns. We will advise the Subcommittee of our additional concerns and specific proposals for resolving them.

The President's proposal has substantial merit and we agree with its overall goals. We look forward to working with Congress, this Subcommittee and the Administration to achieve meaningful health care reform.

Mr. WAXMAN. Mr. Schlackman? There is a button on the base of the mike. If you would push it forward.

STATEMENT OF NEIL SCHLACKMAN

Mr. SCHLACKMAN. Thank you. Good after—I can say good afternoon, I think, now.

You have my prepared statement for the record. I would like to spend the 5 minutes on the keyword, as Mr. Hastert talked about, "quality."

I am a pediatrician, actually a pediatric hematologist, and a medical director at U.S. Healthcare, which is the largest direct contract HMO in the Northeastern United States, with approximately 1.7 million members in 8 States, with approximately 5,200 primary care physicians and 19,000 specialists and contract.

It is the "Doc on the block" kind of issue. It is not a big building where all the physicians are salaried, but, in fact, the doctor on the corner who we contract with.

U.S. Healthcare is and has been an expert in the quality assurance/quality assessment improvement issue for the last 20 years. We applaud and believe that the administration is correct in maintaining that the American consumer should be able to use cost and quality to make choices.

We have been able to demonstrate and have publicized our results in terms of quality improvement in terms of mammography with just about the highest rate of mammography in eligible women in the United States, increased immunization rates, testing of cholesterol, access and satisfaction issues. In fact, just recently we published our information for the public according to a set of very specific data.

We believe that the American public needs that. The employer certainly needs it now. There is strong support for this, especially as it relates to quality, in the Act itself. We need performance measurements, and we need a way to measure it. We need standardization, and we have to have comparable data to be able to make those choices.

There is a lot of information in the literature being used now to measure particular aspects of quality. One can measure access, can measure appropriateness, can measure technical competence, can measure some outcomes, and certainly can measure satisfaction with care. If one is going to value the health care that one gets or wants to get, one needs to be able to value both cost and quality.

It will be a benefit to the consumer, certainly to the patient, and certainly to the employer who is now paying for it.

There are two well-developed measures of quality of health plans now in existence, and my basic plea and concern is that we in fact use what is out there that has taken a great deal of time to develop, and use that as part of the measurement of quality that the Federal mandate should in fact incorporate.

I speak of two issues. One of NCQA, the National Committee for Quality Assurance, which accredits health care plans. It accredits integrated health care plans such as HMO's. It looks at the quality assurance or quality improvement process within them, the utilization management programs, the members' rights and responsibilities, preventive health services, medical records, and evaluates

them as compared to certain very deliberate sophisticated standards.

Recently there has been published something called the Health Plan Employer Data and Information Set. It was developed by employers and health plans. The employers wanted to know what they were buying. Your company that you spoke of would like to know what it gets for the cost that it spends for those 10,000 people, and there has not been until recently any source of comparable data.

This set of data looks at quality in terms of preventive health care measures such as childhood immunizations and it standardizes how one is to report that in a very formal way. It looks at cholesterol measurements, mammography, PAP tests—preventive care that we know makes a difference, and it is important that we measure things that make a difference, not measure things that don't change health care delivery.

It looks at acute care in terms of asthma and admissions for asthma to see what a plan can do to alter the delivery of health care for a susceptible population. It looks at prenatal care in terms of how often women get to the obstetrician because we do know that that makes a difference in terms of ultimately the size and health of that baby. It looks at mental health and how well the patient who is discharged from the hospital gets into that mental health care system thereafter and isn't lost.

It also looks at access to care and satisfaction with that care, and membership and utilization issues and financial issues in terms of financial stability.

There is no need, I don't think, at this point to develop new methods. Those can be incorporated very well into the measures of quality that we all want in order to be able to have a consumer to be able to rate the plan he buys or she buys. The Federal Government should, I think, mandate these kinds of tools since it appears at least that the legislation is not specific, and we don't want multiple measures used by the Federal Government and then by States, and instead of comparability we will get a tower of babble without any information being utilized across the country.

We appreciate the time and I would be glad to answer any questions.

Mr. WAXMAN. Thank you very much.

[Testimony resumes on p. 538.]

[The prepared statement of Mr. Schlackman follows:]

STATEMENT OF NEIL SCHLACKMAN

The terms being used in today's health care debate, the words we hear everyday, words like quality, cost containment, value, outcomes measurement, utilization review, rationing, effectiveness, these are not new words to U.S. Healthcare.

We've been grappling with the challenge of providing quality at reasonable prices for years. We recognize that there is an increased need to justify what and how medicine is practiced and to regard those who do it "right," those who put the emphasis on prevention, for example. And we think that at U.S. Healthcare, we've been doing a pretty good job of meeting that need.

Indeed, we feel we're ready to perform well and to compete effectively in a reformed marketplace. We feel we can succeed as long as the playing field is level and the rules are fair.

U.S. Healthcare (USHC), founded in 1976, is an operator of health maintenance organizations which currently serves almost 1.7 million members in 8 northeastern states. The company contracts with over 5200 primary care physicians, over 19,000 specialists and over 250 hospitals. The majority of the population served live in urban areas, with the greatest concentration in the greater Philadelphia, New Jersey, and New York areas. USHC contracts for care with primary care physicians who are compensated through capitation (i.e. a fixed payment at specific intervals per member for all care provided, irrespective of the number of

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services). The amount of capitation is dependent upon their quality assessment rating and their ability to manage the cost of care effectively.

Indeed, at U.S. Healthcare doctors earn more money when they perform in a superior fashion. We've changed the system to reward certain behavior by doctors and it's working.

In 1987 USHC altered its payment incentives and created a second generation payment mechanism in an attempt to integrate quality of care and service as well as appropriate utilization into the compensation. From 1987 through 1991 physicians were categorized into one of five categories based on specific measurements.¹

In January of 1992 we changed to our current, third generation incentive model and significantly altered our Quality Care Compensation System. We no longer categorize offices. All primary care offices are paid the same **base capitation** determined by the age and sex of the USHC members who have selected the office. This base capitation rate is then adjusted by a **quality factor** made up of three components:

- **Quality review component**
- **Comprehensive care component**

¹ ¹ Schlackman N. Integrating quality assessment and physician incentive payment. 1989. *QRB*;15:234-37.

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- Utilization component

The quality review and comprehensive care components comprise 82% of the quality factor and the utilization component 18%. Thus, the base capitation multiplied by the quality factor is added to the base capitation and results in the actual capitation payment for an office which is paid on the first and the fifteenth of each month. The quality factor is re-assessed every six months.

An important quality review component is member surveys. Determining consumer satisfaction as suggested by HR 3600 is not new for HMOs like U.S. Healthcare. We survey almost all adult members and a subscriber-parent of children, who have recently visited their primary care physicians, each year to collect information on the quality of service in an office. In 1991 we sent out over almost 1,00,000 surveys to attempt to involve members in the evaluation process. There are several reasons why patient participation in care is important.²

With respect to access and to the patient-physician relationship, patients' evaluations of the quality of care they receive are the most practical source of information. Over 10 years of empirical research has produced valid and reliable measures of patient satisfaction with medical

² ² Nash DB, Goldfield N. *Providing Quality Care*. American College of Physicians. 1989; Chapter 2: The patient's role in health care quality assessment. pp 25-69

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care that can be used in practice settings.³ Patients' assessments of care have been shown to affect both the physician-patient relationship and patients' health status. There is evidence that patients want an expanded role in their medical care and that this expanded role may produce better outcomes. If not satisfied or not allowed to participate in their health care, patients may turn to self-care, which may be hazardous.

Patients are surveyed regarding physician availability, waiting time, office personnel, ability to obtain referrals, personal concern of the physician, whether the member would recommend the office to their friends and relatives, and so forth. Data collected from each office are compared with data from all physicians in our system. A detailed report is provided to each office to be used as both a management tool to improve service and a mechanism to compare and value offices. Offices that perform above average are provided increasing additional percentages of the base capitation, up to a maximum of 3.0%. (For those that perform below average, percentages may be subtracted).

Specialists

It is equally important to evaluate the performance of specialists. The need to evaluate the technical quality of care, the appropriateness, and the patient's and primary physician's

³ Davies DJ, Ware JE Jr. Involving consumers in quality of care assessment. *Health Aff*; 1988;7:34-48.

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satisfaction with specialists' care is no less important. It is possible to rate specialists by evaluating primary physician satisfaction with care as well as the patient's satisfaction. Adopting consensus guidelines and evaluating conformance with those guidelines as established by specialty societies, N.I.H., etc. is the basis for the quality improvement process with specialists. Fifteen specialty QI Committees at U.S. Healthcare aid in the adoption of "guidelines" and review the participating specialists ability to adhere to these. For example, the appropriate evaluation of abnormal uterine bleeding, modeled after the American College of Obstetrics and Gynecology guidelines, C-section rates, evaluation of a breast mass, approach to gallbladder surgery all can be measured and rated.

However, the infusion of new technology does not necessarily promote better outcomes (e.g. laparoscopic appendectomies) nor total cost savings. U.S.Healthcare has documented an increase in laparoscopic cholecystectomies, and an increase in the length of stay for open cholecystectomies, and an increased frequency of complications with the introduction of laparoscopic cholecystectomy. With the shift from open to laparoscopic cholecystectomy our total costs have increased rather than decreased. Thus, in this instance, the presence of new technology possibly acquired by a hospital may not have the desired value in this time of health care reform.

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Hospitals

We believe through hard work, innovation and the diligence taken to forge meaningful relationships with hospitals, we have brought dramatic changes to the way hospitals approach care and the cost of it. Though enormously difficult and challenging for most hospitals, a new way of thinking often inspired by U.S. Healthcare usually produces major improvements in care and restraints on costs. The development of contracted networks of providers has altered the traditional "reasonable and customary charges" payment schemes to include strategies which focus on the reduction in the unit price of care ("discounts from charges," and "per diem" rates), and strategies which transfer part of the financial risk for care to the hospital ("per case" rates and capitation). Although the hospital may receive less revenue per patient under these contracting schemes than it would under charged-based reimbursement, this need not imply a net decline in hospital financial condition. Increasing volume delivered to a hospital and stimulating the reduction of the cost of producing a specific outcome may result in a more optimal financial condition.

It is readily apparent that economically meaningful partnerships between purchasers and suppliers are required to create the environment to realize continuous quality improvement. A relationship which shares the gains made through improved hospital performance is consistent with both the spirit and the operational requirements of QI. The forgoing suggests a process

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which involves the specification of performance requirements by the MCO, and incentive payments to the hospital in direct proportion to the improvements in the hospital's performance.

Fundamental to such a contracting system is the capacity to measure relevant aspects of hospital performance. US Quality Algorithms, Inc. (USQA), a subsidiary company of U.S. Healthcare, Inc., has developed such a capacity and routinely supplies measurement services to its parent organization. This contracting strategy -- "Captainer" -- combines base payment with an annual performance-based distribution. The base payment, determined by the actual resources utilized, is considered payment in full for services rendered. The performance-based distribution is made up of components which are designed to reflect the major areas in which there should be mutual and reinforcing commitments to quality improvement:

Service aspects of care

Clinical aspects of care

Structural support for managed care operations.

The relationship between performance and compensation is negotiated on a hospital-by-hospital basis. The performance targets, the development of a schedule towards them, and the construction of a compensation schedule that translates improvement into a performance-based distribution are all individually negotiated by both parties. Reductions in complication

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rates, unnecessary hospital days, and inappropriately high C-section rates all produce financial benefit to the MCO. Improvements in patient and doctor satisfaction also have benefit to the MCO. This system is unique since a) hospitals do not compete with one another for portions of a fixed pool of dollars (each hospital's distribution depends upon its performance only), b) a wide array of performances, including non-financial ones, determine the size of the distribution, and c) the interests of the hospital and the health plan are so clearly and directly linked.

The objective of this methodology is to stimulate improvement in the efficiency and effectiveness of the care and service rendered by primary physicians, specialists, and hospitals that participate with U.S. Healthcare. Interestingly, as a by-product of this system, there has been a significant demand for the information that USQA has provided during the negotiations. This information has been perceived as useful to the hospital managers and medical staff. It may allow internal process improvement efforts to be focused on those processes that enable the hospital to satisfy the needs of the purchaser more appropriately. This partnership between providers and payer is ideally suited to the process of continuous quality improvement.

Performance Reports

Section 505 of HR 3600 requires annual performance reports of each health plan

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offered in an alliance. We strongly support this "report card" concept. In fact, as an active participant with the National Committee for Quality Assurance, we have helped to develop the first comprehensive set of measures that will be used to evaluate and eventually compare the performance of health plans.

The National Committee for Quality Assurance (NCQA) is an independent, nonprofit institution that reviews and accredits health maintenance and managed care organizations. Governed by a Board of Directors of managed care executives, purchasers, independent quality experts, and union and consumer representatives, NCQA is the leading external review organization for the managed care industry.

Established in 1979, NCQA has developed a unique accreditation program in response to increased demand for information on the quality of managed care systems. It is committed to the twin goals of improving managed care organizations' quality of care and service and providing information on quality to purchasers of managed care systems.

NCQA has spearheaded the development and on November 22, 1993, NCQA released the final version of HEDIS 2.0 (Health Employer Data and Information Set), a comprehensive set of measures that will be used to evaluate and eventually compare the performance of health plans.

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The release of the final HEDIS 2.0 has generated widespread support. Over 20 employers have indicated that they intend to require HEDIS reporting of their plans, and the following associations have announced their endorsement of HEDIS 2.0: American Care and Review Association, Group Health Association of America, Managed Health Care Association, and the Washington Business Group on Health.

HEDIS 2.0, first released in draft form in May 1993, incorporates the comments of over 80 organizations in, or related to, the health care industry. It will enable purchasers and consumers to obtain comprehensive, standardized, and comparable information on health plan performance for the first time.

HEDIS 2.0 breaks significant new ground in enabling health plans to standardize how they specify, calculate and report information -- namely quality enrollee satisfaction, utilization and financial data, all standards envisioned in HR 3600. Using HEDIS 2.0 health plans will be able to collect information on performance measures that are indicators of quality care such as Pap smears and pediatric immunizations, measures of quality service satisfaction such as disenrollment rates, as well as over 55 other performance measures.

U.S. Healthcare became the first managed care organization to publish a quality report card based on HEDIS 2.0. Data collection and analysis were performed by U.S.

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Quality Algorithms (USQA), U.S. Healthcare's quality measurement subsidiary. Use of the HEDIS 2.0 standard assures the consumer that information has been collected and reported in a valid manner. This standardized comparative data will provide consumers with the information that they need to make informed decisions.

U.S. Healthcare used 1992 data for its Pennsylvania HMO -- which serves over 600,000 members. Key results were as follows:

- Mammographic screening in women over age 50 has been shown conclusively to reduce mortality from breast cancer. For several years, U.S. Healthcare has worked to improve mammography rates through its U.S. HealthcareCheck program, which includes motivating female members to complete risk assessments, and induce them to obtain mammography, provide automatic referrals to mammography centers, and work-site screening. U.S. Healthcare-HMO/PA's 1992 performance for the HEDIS 2.0 Mammography Rate Measure was 74.2%. The U.S. Department of Health and Human Services, in the publication Healthy People 2000: National Health Promotion and Disease Prevention Objectives, sets a goal for the year 2000 of at least 60% of women over age 50 to receive mammography within the preceding one to two years. U.S. Healthcare has already exceeded this ambitious goal.

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- U.S. Healthcare-HMO/PA's 1992 results for the HEDIS 2.0 Childhood Immunization Rate measure, which assesses the degree to which two-year-olds are fully immunized, exceeded 90% for three of the four individual immunization series. Health People 2000 calls for basic immunization series rates of 90% for two-year-olds by the year 2000.
- U.S. Healthcare-HMO/PA's 1992 HEDIS 2.0 Cholesterol Screening Rate reached 79.9%, which exceeds the Health People 2000 goal of screening 75% of adults for elevated cholesterol by the year 2000.

We attribute our high pediatric immunization and cholesterol screening scores to the success of U.S. Healthcare's Quality Care Compensation System (QCCS) discussed above, which rewards primary care physicians with added compensation for delivering high quality care. Immunization and cholesterol screening rates are among the QCCS criteria.

- Another section of the quality report card focuses on the management of patients with chronic conditions such as asthma. The Asthma Admission Rate measure is intended to assess outpatient care for asthmatics resulting in lower rates of hospitalization. U.S. Healthcare-HMO/PA's 1992 performance shows that only 1.48 members per thousand were hospitalized for asthma. This compares favorably with the Health

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People 2000 goal for the year 2000 of reducing hospitalizations to 1.60 per thousand per year. U.S. Healthcare recently instituted a special program to assist with the management of asthma and the program is expected to result in further reductions in the asthma admission rate.

- The quality report card also includes the results of U.S. Healthcare-HMO/PA's 1992 member satisfaction survey. The responses to the survey question concerning Members' ratings of the overall medical care provided by their primary doctor showed that 93.3% of members rated their overall care as good or better.

We are proud of the results shown in this first set of "report cards". Importantly, the quality report card released by U.S. Healthcare is consistent with the President's proposed Health Security Act which seeks to increase competition and meaningful consumer choice through the availability of valid comparative information on the performance of health plans. We strongly support those sections of the proposed legislation. Clearly, health plans such as ours are prepared today to meet these new standards.

Mr. WAXMAN. Mr. Segal?

STATEMENT OF ELLIOT A. SEGAL

Mr. SEGAL. As always, Mr. Chairman, it is a pleasure to return to the Energy and Commerce Committee.

Obviously, health care is now taking center stage, and many believe this attention is long overdue. President Clinton through relentless attention has elevated the problems of health care to the consciousness of all of us. Many who have devoted our careers to health care hope that this opportunity is not lost on all of you.

The problems of our health care delivery system, of course, are not new to you, Mr. Chairman, nor subcommittee. Over the last decade and a half, you and Chairman Dingell among others have toiled long and hard to bring about and restrain certain kinds of inefficiencies and bring about needed changes in the health care delivery system.

If you would allow me one personal indulgence as a former staff member of the committee, I was pleased to have helped full committee Chairman Dingell in providing revisions to his health insurance proposal and in helping you to draft the Waxman-Kennedy Health Care for All Americans Act. The state of health care in this country would certainly be a lot higher today if either of those provisions were passed.

The topic for examination today is the health plan and how readily PPO's such as National Capitol PPO can adapt and become such a plan. The easy answer is it depends. The form, structure and functions of the plans have to be carefully considered.

Let me assure you, however, that NCPPO will do all it possibly can to become a health plan. Increased reserve requirements, accountability can well serve the public interest. We are not worried about who the alliance structure covers. We are only worried what the requirements might be or that they not be so onerous or that it be so capital intensive as to drive us out of business. We have faith, however, that Congress would not want to do that.

The President's principles are the correct ones. In ranking these principles it is my opinion that universal coverage must be the first tenet. This tenet is crucial to all health plans and to managed competition. Even the Jackson Hole advocates say this. In addition, medical underwriting, preexisting conditions and job status must not be allowed to determine insurability.

PPO's have evolved over the past decade. They were essentially invented by the demands of the public. They are not as confining as HMO's in allowing selection of physicians and not as unmanaged as indemnity coverage. I remember full well Congressman Wyden several years ago became an expert and helped promote and foster the development of PPO's. I must say long before many of us even knew that.

The key points I would like to make for your consideration are the following: PPO's have only been around for about a decade, but there are now close to 90 million Americans who belong to PPO's, in contrast to about 45 million in HMO's. PPO's are the pivotal entities to serve as a logical transition from unmanaged indemnity plans to high structured, more cost effective but very confining HMO's.

It is important to note that a majority of HMO's in this country are IPA models. Most physicians who participate in IPA HMO's also participate in PPO's. These physicians are the key to reform and they need to be provided with inducements to cooperate with health plans. At least 90 million people have to date shown that they want to have access to providers and other practitioners of choice. It should be noted that there still are approximately 100 million other Americans who are not yet in either HMO's or in PPO's or in a program that we would call a significant managed care program.

In exploring all your options, I would suggest that the committee keep in mind and try to balance two issues, unnecessary requirements that might be imposed upon future plans and the possibilities of unintended consequences. In the interest of time, I would not spend much time on the issue of PPO's other than to just say that you all as a committee explored PPO legislation during the mid-1980's and at that point were correct in not moving ahead with regulations at a time where they were needed to grow and foster, and I commend you all for doing that. A more important anecdote for me is the relatively unnecessary requirements that might refer to risk taking.

Can I have a minute?

PPO's have traditionally not taken risks, but the most important thing that comes with this is to require that there are unintended consequences if too many Americans remain under- or uninsured. There are 25 million who would remain uninsured under managed competition plans that do not call for universal coverage.

If this happens, there will be an important distinction between the Clinton proposal and the managed competition proposal, and that is, namely, that we would as operating PPO's have to go out of our way to preclude or to select against those physicians and those hospitals who try most to provide compassionate care to people who are underinsured.

With that I am available as well for questions.

Mr. WAXMAN. Thank you very much, Mr. Segal.

[The prepared statement of Mr. Segal follows:]

TESTIMONY
OF
ELLIOT A. SEGAL

As always it is a pleasure to return to the Energy and Commerce Committee.

Obviously health care is now taking center stage and many believe this attention is long overdue. President Clinton through relentless attention has elevated the problems of our health care delivery system to the consciousness of all. Many of us who have devoted our careers to health care hope this opportunity is not lost.

The problems of our health care delivery system are not new to you, Mr. Chairman, and this Subcommittee. Certainly during the past decade and a half, you and Chairman Dingell have toiled to improve the status of our nation's health, to restrain necessary care cutbacks, and to make the system more cost effective.

Prior to that you and other members of the Oversight and Investigations Subcommittee played a major role in identifying substantial areas of waste, fraud and abuse. The debate today depends upon creating systemic and management improvements to eliminate wasteful practices you uncovered in order to pay for needed care for underserved citizens. Some progress has been made. During the mid-1970's the American Hospital Association (AHA) opposed second opinions prior to elective surgery and the AHA opposed uniform reporting and accounting practices. At least many of those issues are behind us.

If you would allow me a personal indulgence, as a former staff member of this Committee, I was pleased to have helped Full Committee Chairman Dingell in providing revisions to his Health Insurance proposals and to have helped you in drafting the Waxman-Kennedy Health Care for All Americans. The state of health care in this country would be higher today if either of these bills had become law; but of course they did not.

Now we are at a crucial crossroads with the first major chance since 1974 to remedy major gaps in health coverage. President Clinton must be commended for the package he has proposed. Along with the First Lady, and a large cadre of experts, both in and out of government, they developed a sophisticated proposal after an extraordinary amount of listening, diagnosing and synthesizing the positives and negatives of our current delivery system. This reform package provides distinct opportunities to make lasting changes in the quality of health care for the citizens in this country.

The topic for examination today is the Health Plan and how readily PPOs such as National Capital PPO can adapt and become such a Plan. The easy answer is "it depends." The form, structure, and functions of "Plans" must be carefully considered. No matter how well intentioned, if the regulation of Health Plans is too confining or doctrinaire it could even serve to undermine positive aspects of our current byzantine system. One must put "Plans" as well as the National Board and Health Alliances into an appropriate context.

Let me assure you that NCPPO will do all it possibly can to become a Health Plan. Increased reserve requirements and accountability can well serve the public interest. We are not worried about whether the Alliance structure covers employee groups as low as 50 or as high as 5000. We are only worried that the requirements might be so onerous or capital intensive as to drive us out of business. We have faith that Congress would not want to do that.

The President's principles are the correct ones. In ranking these principles it is my opinion that universal coverage must be the first tenet. This tenet is crucial to "Plans" and managed competition. Even the Jackson Hole Advocates say this. In addition medical underwriting, pre-existing conditions, and job status must not be allowed to continue to determine insurability. Limited benefit packages and unaffordable coverage can no longer be tolerated. The public is demanding that these key principles be adopted and I believe that Congress will show the wisdom and imagination to meet these needs of the people.

In looking at existing PPOs or even HMOs or insurance companies and imagining how they can become "Plans" a myriad of problems, imponderables, and even scary prospects quickly emerge. Who will be these Alliances that will determine the fate of "Plans"? Every bad experience with a bureaucracy - be it an insurer, a government entity, or some computer generated mistake - suddenly becomes projected onto the Health Alliances. This clearly is a case of the enemy we know being better than the enemy we do not know.

I can read through the President's proposal and identify many unanswered questions and issues that need to be resolved in a reasonable logical way. I have identified as Appendix A, a compilation of several items that will have an impact relative to Health Plans. Most of these issues will require that PPOs change to some degree to comply with likely standards.

PPOs have evolved over the past decade. They were essentially invented by the demands of the public. They are not as confining as HMOs (in allowing selection of physicians) and not as unmanaged as indemnity coverage. There exists a vast spectrum of PPOs which have basically emerged in local markets to meet local needs. Some focus on discounts, others offer large unmanaged networks, still others carefully choose their practitioners and manage the care of their patients as well as the better functioning HMOs.

The key points I would like to make for your consideration are the following: PPOs have existed for only about a decade - about half as long as most HMOs. There are now probably close to 90 million Americans who belong to PPOs in contrast to about 45 million in HMOs. PPOs are pivotal entities to serve as a logical transition from unmanaged indemnity plans to highly structured more cost effective but very confining HMOs. It is important to note that a majority of HMOs in this country are IPA models. Most primary care physicians who participate in IPA HMOs also participate in PPOs. These physicians are the key to reform and they need to be provided with inducements to cooperate with Health Plans.

At least 90 million Americans have to date shown that they want to continue to have access to physicians and other practitioners of their choice. They have demonstrated a willingness to on occasion - by their choice - pay additional deductibles and co-payments to keep their practitioners. They do this by participating in PPOs. However, there are currently an estimated additional 100 million Americans who are not yet in a managed care environment of either PPO or HMO. Broad efficiencies and very significant cost savings can accrue from having these individuals move into managed plans with higher quality and lower costs than their current arrangement. PPOs that manage care are the most logical structures to absorb a large majority of these unmanaged health care recipients. The Clinton proposal recognizes that there needs to be plans like PPOs. Most PPOs, however, appear fearful of the Health Plan, Health Alliance, and Health Board structure. It is unclear to me at this point in time whether these fears are real or unfounded.

There are a multitude of issues that will impact upon "Plans" and on who will become such entities. Again many of the tasks and responsibilities of "Plans" will depend upon the statutory and regulatory results of the legislative process.

In exploring options, I would suggest that the Committee keep in mind and attempt to balance two issues:

- a. Unnecessary requirements imposed upon future "Plans", and
- b. Possibilities of unintended consequences.

I will provide anecdotes for each:

Relative to imposing unnecessary requirements, I will harken back to legislation introduced in the mid 1980's to establish certain standards for PPOs. At that time, I was asked to testify and suggested the PPO movement was in its infancy and the emerging models might be harmed by premature standard setting.

Time has shown that this Committee was correct to forego early legislation and regulations. Now I believe that certain types of trends have emerged that will allow standards and accountabilities to be set. There are a large number of PPOs that have taken strong steps to manage networks plus monitor and

manage the care of patients. We have demonstrated utilization review and patient management techniques that lower costly treatments and coordinate care. We also rationalize provider payments, and are in the early stages of attempting to track patient quality outcomes. We even attempt to curtail unbundling and other financial abusive practices that were examined extensively over the years by this Committee. These PPOs should be fostered and encouraged. There certainly is no problem in calling these entities Health Plans as long as PPOs can evolve to Health Plans without being destroyed in the transition.

At the same time there are a number of PPOs who essentially do nothing more than sell their discounts to purchasers and keep a portion (often 20% or 25%) of the savings. It is not clear to me that there is a public interest that is served by this practice.

A second anecdote relative to unnecessary requirements refers to risk taking. PPOs have traditionally not taken risk. Many are hospital sponsored, where the facility serves as the risk taker. Other PPOs are in effect subcontractors to insurers of self-funded employers or Taft-Hartley Trusts; often with stop loss or minimum premium arrangements. PPOs are just beginning to create new innovative and creative risk sharing arrangements that package physicians and hospitals together in risk sharing arrangements that encourage effective patient care. Cookie cutter "Plans" requirements could chill such emerging programs. However, Congress must deal with reserve requirements. My suggestion is that you review the HMO requirements of states such as Maryland.

The central issue that the Congress must focus upon is that of universal coverage. Without universality we run the distinct risk of an unintended consequence, namely eliminating our most caring institutions and physicians from participating in managed competition.

For example, if 25 million Americans remain uninsured or under-insured under managed competition they will end up being treated by the most compassionate and

or most geographically accessible hospitals and practitioners. There is no doubt in my mind that in an intense market sensitive milieu Health Plans will need to avoid these providers to survive competitively. Hence health reform without universality will distort the marketplace and unnecessarily jeopardize the survivability of providers, particularly hospitals.

It should be noted that the Jackson Hole managed competition proponents propose that there needs to be universal coverage for managed competition to work. Otherwise, argues Alain Enthoven, the system would be destroyed by "free riders".

I would be very surprised if anyone using the California PERS system as the model of a competitive system would believe that program could function appropriately if State employees in Sacramento, San Jose, San Diego and Stockton were uninsured.

There are other problems that should be identified where the suggested solutions may bring about unintended consequences. For example, there are not enough primary care practitioners which the Clinton plan speaks to. This shortage is particularly acute in underserved inner cities and rural areas.

This problem was also addressed by health manpower legislation in the 1960s. Most medical schools then accepted the additional money to train more physicians. In spite of this push for more primary care physicians, we have ended up with a greater proportion of specialists and continuing shortages in inner cities and rural areas.

Another approach might be to encourage health plans and health training facilities to plan for more efficient delivery systems in the 21st century. When one looks at the demographics, the new interactive computer and video capabilities applied to medicine, and integrated health team delivery of care; "Plans" of the future in central city and rural areas (as well as all areas) could well be better off with nurse practitioners, physician assistants, and telecommunications techniques for treating patients rather than hoping for more primary care physicians.

The last primary care physician training initiative demonstrated that most medical students did not want to become primary care physicians and medical schools as structured did not have the resolve or could not adapt to train such physicians.

The lack of primary care physicians is not going to be solved in the short run in any scenario. The solutions of this provider coverage problem should at least consider technology transfers from areas such as the defense industry particularly systems integration expertise.

I would like to conclude by saying that most people in the health care industry know that change is inevitable and that providing Third World medicine to a portion of our population is a shame that Government should remedy. The vast majority of providers, including HMOs and PPOs will roll with the punches and retool over time. Grumbling and dissent will be minimized if the reform programs are fair and logical.

As a footnote, no matter what happens in Congress this next year, health care delivery will affect everyone including you, your family, and your staff. On that note let me assure you that National Capital PPO intends to do what is necessary to become a Health Plan and maintain our high quality network. And if Congressman Stark's provision relating to Members of Congress prevails, I hope you will consider joining NCPPO. You would certainly gain first hand exposure to the unique geographic and coverage issues that face the District and other multi-jurisdictional cities.

Thank you for the opportunity to testify before you. I am happy to try to answer any of your questions or assist in anyway you would desire.

APPENDIX A**

Specific Issues of Concern for PPOs in Becoming a Health Plan

1. Health Plans must contract
 - a. with designated providers
 - b. with centers of excellence
2. Requirements that an Alliance establishes a fee schedule for fee for service component of a Health Plan.
3. Determine financial incentives to get Health Plans to serve disadvantaged groups.
4. Requirements that a Health Plan must provide will be required to provided numerous unspecified standardized information.
5. Health Plans must verify credentials periodically.
6. Health Plans must disclose utilization management techniques, protocols, performance measures, selection criteria, etc.
7. Health Plans must limit premiums and rate of increase of premiums.
8. Health Plans must maintain discrete electronic documentation of all clinical encounters with health providers.
9. Health Plans must create a point of service information system to electronically move clinical, administrative, and payment data.
10. Health Plans must utilize standard forms for enrollment, clinical encounters, and insurance reimbursement.
11. Health Plans must establish alternative dispute resolution systems using models developed by the National Health Board.
12. Health Plans must operate within anti-trust safe harbor rules for negotiating prices.

** Depending upon how rigorous the requirements are, these issues may or may not be restrictive.

Mr. WAXMAN. Dr. Fishbein?

STATEMENT OF DAN FISHBEIN

Mr. FISHBEIN. Thank you, Mr. Chairman, for the opportunity to appear today. I am Dr. Dan Fishbein, a Vice President at New York Life. I have responsibility for managed care products, including work with New York Life's HMO and PPO networks across the country as well as our more traditional fee-for-service plans. My testimony is offered on behalf of the Health Insurance Association of America.

Mr. Chairman, the HIAA is committed to working with the administration and the Congress to achieve comprehensive health care reform that will provide universal coverage at affordable costs. We support cradle-to-grave coverage for all Americans, and we support changes in the rules governing the insurance industry so that such coverage can be assured.

However, we do have concerns about some features of H.R. 3600. I will focus the remainder of my oral remarks on the impact of health alliances and accountable health plans on fee-for-service plans.

We have one overriding concern about the effect of the alliances. Simply put, fee-for-service plans cannot survive in a mandatory health alliance structure. The health alliance structure was designed to foster competition amongst a limited number of HMO's. It was not designed to allow fee-for-service plans or other plans offering meaningful provider choice to survive.

We recognize that H.R. 3600 purports to require that fee-for-service plans continue to be available. However, two features of the bill would combine to effectively eliminate fee-for-service plans.

First, the alliances are mandatory; that is, all Americans except those who work for the largest employers are required to purchase their health coverage from an alliance. Second, each individual chooses his or her health plan. This will result in adverse selection against plans with the greatest choice of providers and put those plans into what is called a death spiral.

The death spiral of plans offering the greatest provider choice would come about as follows. Under the health alliance structure, each person who will get coverage through an alliance will individually determine which plan to enroll in. Plans with greater choice of provider are inherently and legitimately more costly than tight network plans. People with existing health conditions and others with existing relationships with doctors will on average be less willing to choose a restricted network system such as an HMO. Instead they will be willing to pay a somewhat higher premium for a fee-for-service plan or PPO plan that allows them to have access to any providers they choose.

In contrast, healthier people with no or only one significant physician relationship are more likely to be willing to select a lower cost, more restricted network plan. Because the alliance structure will produce the systematic anti-selection that I just described, the plans with greater provider choice will attract a population that will require more health care services than the population in HMO plans.

Plans allowing greater choice will be forced to increase their premiums when allowed in order to remain financially viable. As a result, each year the price differential between HMO's and plans with greater provider choice will increase beyond that attributable to the structural controls imposed by network plans.

As the price differential increases each year, some of the healthier individuals who initially enrolled in the fee-for-service plans will then decide that the cost is too high and they will switch to a more restrictive plan. As a result, the fee-for-service plan will cover an even higher cost population on average, forcing the premiums for that coverage to be increased even further to cover claims.

The pattern will repeat itself each year. Within 3 or 4 years, plans offering unrestricted provider choice will become unaffordable, except for the very wealthy.

Mr. Chairman, it is ironic that while proponents assert that the health alliance structure will provide greater choice for the individual as a result of this death spiral consumers will actually lose access to plans which allow the greatest provider choice. I suggest that this is the choice that most Americans really want to preserve, the ability to choose their health care provider at the time that medical services are needed, not the ability to choose their health plan from amongst a large number of tightly restricted network plans such as HMO's.

Some people have suggested that this anti-selection problem can be addressed by use of a risk adjustment mechanism. We remain very skeptical that any risk adjuster can be effective in a system in which every individual chooses his or her plan, and the next panel will discuss risk adjustment in more detail.

We suggest that an appropriate alternative to mandatory health alliances is to test some type of purchasing cooperative on a voluntary basis, under a voluntary approach which is premised on insurance reforms that would apply to all plans, employers and individuals would not be forced to purchase coverage through an alliance or cooperative. They would have the option of purchasing through the cooperative or obtaining coverage directly from a health plan.

However, a voluntary alliance system will allow the employer-based market to survive outside the health alliance structure. In this market where insurers cover groups of individuals through their employer, the spread of risk is sufficient to allow fee-for-service and other free choice plans to survive.

We would also again suggest that the same rules apply to all plans inside and outside the alliance.

Thank you.

Mr. WAXMAN. Thank you very much, Dr. Fishbein.

[The prepared statement of Mr. Fishbein follows:]

STATEMENT OF HEALTH INSURANCE ASSOCIATION OF AMERICA

Good morning, Mr. Chairman and Members of the Committee. I am Dan Fishbein, M.D., Vice President, Group Department of New York Life Insurance Company. I am here today on behalf of the Health Insurance Association of America which represents approximately 270 commercial insurers covering approximately 65 million Americans. The HIAA again welcomes the opportunity to provide you with our views on health care reform.

Mr. Chairman, we commend the President for coming forward with an ambitious blueprint for reform of the nation's health care delivery and financing system. In communications with the Administration, Members of Congress, and the general public, HIAA has repeatedly stressed its wholehearted support for the principles outlined in the President's reform package, and has proposed specific means by which they can be implemented. Let me again emphasize what we're for:

- *"Cradle to grave" coverage for all Americans.*
- *No exclusions for existing or previous illness.*
- *Coverage that cannot be canceled if you get sick.*
- *If you change jobs or lose your job, coverage goes with you.*
- *Employers and employees both pay toward coverage.*
- *Subsidies for those who cannot afford premiums.*
- *Control of malpractice lawsuits and unnecessary tests.*
- *Publish price and quality data.*
- *Single claim form to control paperwork.*
- *Incentives for healthy lifestyles, and an emphasis on wellness and prevention.*
- *Stop shifting costs of Medicaid and Medicare to those with private insurance.*
- *Using managed care to control costs.*

While the HIAA strongly supports comprehensive reform built on universal coverage, we have serious doubts about some of the features of the Administration's plan. In the broadest sense, the President's plan erects an enormously complicated bureaucratic structure which could undermine, not foster an improved system. The HIAA believes it is appropriate for the government to establish guidelines and rules governing a reformed system. We do not believe, however, that government should, in fact, run the system.

HEALTH ALLIANCES

The President's bill calls for the creation of large, government-mandated purchasing pools through which everyone, except persons employed by an employer with more than 5,000 employees would be forced to purchase insurance. The theory underlying this concept is that a large pool of purchasers will have significant market clout to bargain for low-cost health care — market clout which small employers lack today. These mandatory government alliances will be responsible for contracting with State-certified health plans pursuant to the criteria established by a State under Title I, Part 1, Section 1203(a). This theory has not been tested or proven. Moreover, today carriers aggregate small and medium-sized employers for the purpose of negotiating rates with providers. These negotiated rates are then available to all of the carriers' employer clients, regardless of their size.

All individuals and employers with less than 5,000 employees will be denied key choices in the new system. First, they may not be allowed to retain their current insurance. That is because not all plans will be allowed to compete in the new system. What happens to those consumers who want to retain their current plan? Second, they will not be able to choose to use an agent or broker, who is, in essence, a benefits advisor to the employer. Third, in a state which elects to establish a single-payer health care system, there will be no choices of health plan at all (Title I, Subtitle C, Section 1223(b)(2), page 111). This does not seem consistent with the goal of consumer choice or the goal of competition.

Proponents of these alliances suggest that significant administrative savings can be realized. HIAA believes such savings have been overestimated. Certain administrative functions must be performed by the alliance. These include plan enrollment, premium collection, claims payments, and fraud detection. Under the President's plan, enrollment is handled through the alliance. Today, employers handle employee and dependent enrollment. That cost is not reflected in their insurance premiums. Most employers send premium payments directly to the insurer or health plan. Under the President's bill, the alliance will not only handle enrollment, but will also collect the employer and employee share of the premium, forward premium payments to the plan selected by the employee, assemble and disseminate health plan marketing information, negotiate fee schedules with providers, and mediate disputes between individuals and their health plans. This can result in significant administrative expense for the alliance when one considers that everyone except employees of the very largest employers in the region must purchase coverage through the alliance.

The Administration characterizes regional alliances as simple purchasing cooperatives providing individuals and small groups with buying leverage in the market. Their alliances are not, however, simple purchasing cooperatives. They are organizations with huge budgets, considerable authority and a broad range of responsibilities. Laura D'Andrea Tyson, Chair of the President's Council of Economic Advisors, stated recently that the alliances will require 50,000 employees to operate them. The breadth and

scope of activities of these regional alliances exceeds that of most existing agencies of state government today.

Health alliances are untested. The six states that have authorized purchasing alliances in place have made them voluntary, not mandatory, as proposed in HR 3600 and other legislation; only one is currently operational. The Administration's bill requires anyone who works for a company with less than 5,000 employees, and all people with individual health insurance coverage to enroll in the new alliance structure. In essence, that means that 80% of all Americans, roughly 200 million people [these numbers include everyone except 30 million Medicare recipients and 20 million workers and dependents whose employers would be eligible to establish Corporate Alliances. Source: "Congressional Health Care Workshops" materials dated September, 1993], will be receiving health coverage through an untested alliance system. There is no precedent for such massive change to a process so essential to the welfare of all Americans. In addition, according to a June 1993 "Harvard School of Public Health" survey, 77% of Americans surveyed are pleased with their health care coverage.

One alternative to monopoly health alliances is voluntary health alliances. HIAA would favor testing purchasing cooperatives or alliances on a voluntary basis. Employers and individuals would not be forced to purchase their coverage through the alliance, they would have the option of purchasing through the alliance or obtaining coverage directly from a health plan. This would not create "loopholes" to allow underwriting to continue. All health plans, whether or not they participate in the health alliance, would have to play by the same rules so that neither the plans operating within the alliance nor plans operating outside the alliance would receive an inequitable share of risk. Insurance reforms, such as the elimination of pre-existing condition limitations, and guarantee issue of insurance, along with a risk adjustment mechanism, would be applied to all plans — both inside and outside the alliance.

Rather than discuss purchasing alliances in terms of theory, I'd like to discuss a real working program. There currently are six states which have passed purchasing alliance legislation; all six have passed voluntary alliances. Although one other state has an operational pool, only California is actively and aggressively marketing the purchasing pool as a competitive alternative in a reformed marketplace. In February of this year, one of HIAA's member companies, Employers Health Insurance, was hired by the state of California to administer and market that program. I would like to provide some background on that program to illustrate, based on its short experience, how things may occur in the real world.

In 1992, the California legislature passed a comprehensive small group reform bill. AB. 1672 included sweeping underwriting and rating reforms and provided guarantee issue of all products to employers with 5 to 50 employees (4-50 in 1994 and 3-50 in 1995 and thereafter). The law also limited pre-existing condition clauses, provided for portability of pre-existing condition clauses, and enacted guaranteed renewability of groups of all

sizes. In addition, the new law created the Health Insurance Plan of California (The HIPC), the first statewide small group purchasing alliance.

Like most such purchasing alliances under discussion federally, the California plan was designed to aggregate the buying power of small employers, offer individual employee choice of an array of health plans, and centralize certain administrative functions in an effort to lower costs. The HIPC is a voluntary program, operating in competition with a reformed, outside market. Currently 18 carriers offer a choice of 19 health plans (16 HMOs and 3 PPOs), with benefits standardized through regulation. A total of four benefit plans are offered through the HIPC, two PPO plans and two HMO plans, a high and low option in each with the only difference between them being cost sharing provisions. Not all plans are available in all areas, however, there is no area in the state with fewer than four choices. State law allows for some minor variation in rates due to health status outside the alliance. However, premiums within the HIPC are community rated by class, allowing for rate differentials based only on benefit plan, age, geographic location and family status. In other words, premiums cannot vary due to health.

Employers make the decision whether to participate in the HIPC program. If the employer chooses the HIPC, the individual employees choose whichever health plan offered in their area they feel best meets their individual and family needs. Employers participating in the HIPC are required to contribute a minimum of 50% of the least expensive premium for "employee-only" (single coverage) in their area. Currently, the average employer contribution is 80 percent.)

The pool became operational May 10, with effective coverage starting July 1, 1993 when the reform law became effective. As of December 1, 1993, more than 1400 employer groups and 24,513 individuals are covered in the program.

While few conclusions can be reached with just four months of data, some interesting trends are beginning to develop. For example, despite the fact that employers are able to purchase coverage directly from the HIPC and avoid the costs associated with agent commissions, 79 percent of the HIPC's current business was sold through independent agents. This indicates to us that small employers value the services of an independent counselor when selecting employee health benefits — so much so, they knowingly pay an additional cost for it.

Price competition is an important feature of the program and the reformed outside market, but individuals are not choosing the lowest-cost plans available to them. Instead they are gravitating toward the "lower cost" plans, that is those plans in the lower-half price range of the plans available. Prices within the HIPC are, on average, about 10 percent lower than plans offered in the outside market, due mainly to limited benefits. However, for every employer that purchases coverage through the HIPC, another five employers look at the program and choose to buy elsewhere. In a

mandatory purchasing environment those employers would not have the choice of purchasing elsewhere.

We have been able to gather some demographic data to date. Fully 80 percent of the individuals covered through the HIPC choose one of the HMO options, split evenly between the high and low cost-sharing provisions. Twice as many of the remaining 20 percent choose the "high" PPO option as compared to the "low" PPO option. The demographic breakdown of the individuals covered mirrors a "typical" breakdown in the California marketplace. It is important to note that managed care has higher market concentration in California than most other states. Nearly 80 percent of the individuals covered through the HIPC are under the age of 50, 60 percent are under the age of 40; males slightly outnumber females; the average group size is just over nine employees, and the average family size is just under two people.

Although limited and certainly not statistically credible, the California experience so far suggests many things. In a reformed market, voluntary alliances are able to compete, provide an array of choice, cause competition to focus on service and price, and put the individual consumer in the driver's seat. We don't know exactly why, but it would appear that alliances may not be the best answer for rural communities. So far, the vast majority of participants in the HIPC come from the most populous areas of the state, with Los Angeles drawing the most participants, San Francisco second, and San Diego third.

If health alliances are truly more administratively efficient, and better at pooling risks, then the carriers operating through the alliance will have lower premiums and will naturally gain market share. If, on the other hand, employers and individuals prefer to deal directly with an insurance company or HMO, rather than a large government bureaucracy, they should have that choice. The market, not the government, should determine which is the more efficient way to cover all Americans. A voluntary approach to pooling mechanisms would provide the opportunity to test the theory of the alliance approach, without gambling the security and future of health care coverage for all Americans in the process. In a mandatory approach where do the millions of Americans go if the system doesn't work? The infrastructure that previously served them will no longer exist.

ACCOUNTABLE HEALTH PLANS

HIAA is convinced that the mandatory health alliance system and the accountable health plans proposed in H.R. 3600 and other federal legislation would rapidly lead to the demise of fee-for-service and other plans that provide coverage for out-of-network services. Even though these proposals purport to require that these plans continue to be offered, the structure of the proposed system cannot support fee-for-service plans. This is significant because the effect will be to eliminate from the health care system

those plans that offer individuals the ability to choose their provider at the time they need medical service.

HIAA notes that the direct limitation on plan availability outlined in the Administration's September 7 "Working Group Draft" has not been retained in the bill. Under Title I, Part 2, Section 1321(a)(1) "... each regional alliance shall negotiate with any willing State-certified health plan...." While this does reflect an improvement over the "Working Group Draft," it does not address HIAA's concerns about plan availability. First, under Section 1321 (b)(1) an alliance could reject a State-certified health plan if its proposed premiums exceed by 20 percent the weighted average premium within the alliance.

Second, the health alliance structure envisioned in the Health Security Act effectively bars the entry of new plans after the initial years. In addition, plans not selected in the first year will be unable to compete in the region, and will not be around to bid the following year. Within a few years, only a handful of competitors will remain in each alliance area. The plans that survive may not be the most efficient and effective. Success in the early years of the alliance may depend more on a plan's ability to "sell" itself to individual consumers through media advertising, than on the quality or efficiency of the care it delivers. The plan creates a disincentive for competition based on quality of care and service. The increased emphasis on mass marketing and name recognition is likely to constrict the market. If consumers do not like the plans offered through the alliance, because of poor quality care or service (for example, they can't get their calls to the 800 number answered), they would not have any alternative -- it is the "only game in town."

The alliance or the purchasing pool as it is referred to in other congressional alternatives, would allow individual families to select which contracted health plan they wish to enroll in. The premium each plan charged to each family would not vary based on their health status. (Most proposals call for pure community rating, under which the premium charged would not vary at all, except perhaps by family type.)

Proponents argue that, under this sort of proposal, individuals would have greater choice of plans through the alliance or purchasing pool than they have under the current system, in which employers decide how many and which health plans will be offered to their workers.

This may be true, at the outset. But the range of plan choices within the alliance or purchasing pool would narrow considerably over time. In particular, plans that offer consumers a wide choice of providers (i.e., fee for service and PPOs) would become, over time, less and less affordable relative to more restrictive network plans. They would eventually be priced out of the market, becoming unaffordable to most consumers or, perhaps, unavailable altogether. Because the type of plans eliminated will be those with greatest out-of-network coverage, the effect will be to limit the individual's choice of provider at the point of service.

This "death spiral" of plans offering wider choice would come about as follows: People with existing health conditions or problems tend to have established provider relationships that they are satisfied with. Thus, they are less willing (than relatively healthy people are) to enroll in network-based health plans which limit their choice of provider or which pay significantly less if non-network providers are used. Healthier people with no (or only one) significant physician relationship can, if they wish, select a more restricted network plan. But people with serious or multiple medical problems will probably not be content with a restricted network.

Under mandatory alliances, in which each individual selects his or her health plan, plans offering wider choice would attract a higher proportion of people with medical problems. As a result, their premiums would be higher than those of plans that offered more limited provider choice. (Wider-choice plans are expected to cost somewhat more than tight network plans due to differences in the extent to which they are able to manage care. While premium differentials based on real differences in the effectiveness of care management are desirable, premium differentials based on the relative health of the population enrolled are not.)

Because the desire for free choice is very strong, many consumers will be willing to pay a little extra to maintain it. Therefore, we expect that initially, wider-choice plans are likely to enroll some healthy consumers as well as relatively unhealthy ones. But healthy consumers have fewer strong provider relationships; they are not likely to pay significantly higher premiums in order to maintain free access to any physician. As premiums increase, they will choose a less expensive network plan. Thus, over time, the wider-choice plans will lose healthy members while retaining unhealthy members, necessitating an even larger differential between the premiums of plans with wider choice and premiums of restricted networks. Each year, as more healthy members are lost, premiums will increase further beyond those of the tight network plans. Eventually, plans offering unrestricted consumer choice will become unaffordable, except for the very wealthy.

Thus, within a very few years, consumers buying through mandatory purchasing pools or health alliances will lose access to wider-choice health plans. Non-network, or fee-for-service, plans will disappear first. Then network plans that offer some degree of choice will be forced to become more restrictive and limit coverage of non-network providers. If they fail to do so, they will be priced out of the market as well.

I want to emphasize that HIAA strongly supports the continued development and evolution of integrated, network-based health plans that manage care. Experience has demonstrated that efficiency and quality of care can be improved as providers are organized into networks that actively monitor the care provided to their enrollees. Therefore, we believe that managed care is the best alternative for controlling the cost of health care in the United States while maintaining or improving the quality of the care provided.

At the same time, the personal relationship between physician and patient is recognized as an important part of the healing process, and we know it will never be possible to guarantee that every network will offer enough providers to assure that every enrollee will find one they are comfortable with or whose specialty is needed by the patient. Families with several primary care physicians — pediatrician, gynecologist and internist, may find them all associated with different networks. In addition, a person with a family history of heart disease, for example, may want to preserve the option of consulting with specialists at a later date. For these reasons, we think it is very important to maintain a "free choice" option in a reformed health care system.

As I have outlined above, we believe that free-choice plans will not survive as an affordable option if everyone, or almost everyone, must arrange their health care coverage individually through monopolistic alliance or purchasing pools. This remains true even if the pools are legally required to offer fee-for-service type plans. Free-choice plans are viable over the long term only if they are able to enroll groups that include representatives of both the healthy and sick, as in the current system where employers arrange coverage for their employees with a limited number of health plans.

Thus, if we are to preserve Americans' access to wider-choice health plans over the long term, we must preserve an option for employers to arrange health coverage for their workers on a group basis outside of local purchasing pools or health alliances.

Proponents of mandatory, or monopolistic, alliances or purchasing pools argue that this "death spiral" scenario for wider-choice plans could be avoided if payments to health plans were varied based on the real differences in expected costs (risk) presented by people with different needs for medical care. For reasons discussed in our separate testimony today on the topic of risk adjustment, we are not convinced that a risk adjuster can be developed and implemented which is able to remove or significantly reduce the effects of adverse selection on premiums where individual consumers select their health plans. Simply put, each person will always know more about his or her own health situation than can be determined by outsiders who must rely on objective, external observations about each consumer.

TRANSITIONAL INSURANCE REGULATIONS

The transition to a new health insurance market could take several years, especially if the new market structure is as complex and unwieldy as the President proposes to make it. The Administration's bill specifies under Title XI, Section 11003 (a)(1) that "each health insurer that provides a group health insurance plan may not terminate (or fail to renew) coverage for any covered employee if the employer of the employee continues the plan, except in the case of (A) non-payment of required premiums, (B) fraud, or (C) misrepresentation of a material fact relating to an application for coverage

or claim for benefit." An identical prohibition is also set forth in the bill for individual health insurance plans.

We would oppose any attempt to prohibit insurers from withdrawing entirely from the health insurance business or any significant part of it, such as the individual market or the small group market. Government should not coerce any corporation or person to continue in any particular line of business.

During the transition the Secretary of HHS is authorized to set up a National Transitional Health Insurance Risk Pool funded by premiums and assessments against all insurers based on market share in the health insurance market. This constitutes yet another cost to insurers.

However, HIAA would support some of the proposed rules. In fact, they closely parallel insurance reforms we have been promoting at the state level for several years. I refer here to such requirements as guaranteed renewal of coverage, automatic acceptance of new entrants in currently covered groups, and portability improvements which prohibit exclusion of coverage for pre-existing conditions when previously insured people change jobs or their employers change carriers. These reforms can be implemented very quickly, and do not require a new bureaucratic structure the President proposes. We would caution that it is imperative that implementation of the transition rules be coordinated with the phase-in of universal coverage.

Other proposed transition rules present severe difficulties for insurers. The rules establish de facto premium caps by giving states the right to approve or disapprove rate increases as specified in Title XI, Section 11004. For reasons explained earlier in greater detail, we oppose limiting insurers' ability to charge rates sufficient to cover the real costs of serving their enrollees.

There are also administrative problems with the proposed interim rating structure. It differs significantly from the rating reforms that have been enacted in more than half the states in the past three years and will therefore require significant time and administrative effort on the part of both states and carriers to implement, all for a scheme that would remain in place for a year or two.

CONCLUSION

In conclusion, I want to again emphasize that we support more of the President's plan than we oppose. We have been a responsible participant in the national health care debate and want to work with the Administration and Congress to develop national reform which achieves universal coverage, promotes individual responsibility and cost containment, preserves choice and maintains the quality of our health care system. During this discussion, we must remember that our health care system has many excellent features and we should build on them.

Johnston/Reynolds 10/20/93 10:00 AM

Mr. WAXMAN. Ms. Lore, you testified against the requirement in the President's bill that all health plans offer essential community providers; that is, community health centers and other providers that have traditionally served the poor, a choice of participating in the plan on the same terms as other providers or being paid at a specified rate for serving plan enrollees.

This requirement would sunset after 5 years unless the Secretary of HHS chose to extend it and the Congress did not overrule that decision. You argue that this requirement could create major difficulties for Kaiser and other health plans, making you indemnity insurers for these providers with no ability to oversee quality or control their costs.

Mr. Segal also listed this requirement as a number one concern of PPO's in becoming health plans. As you know, I don't think the President's plan goes far enough in addressing the needs of underserved populations, and I am very worried that without adequate protections essential community providers will not be able to survive the implementation of the President's plan, leaving low income neighborhoods without a health care delivery system.

The financial incentive for health plans to avoid these providers and their high risk patients are too strong, and the financial consequences to those providers of losing their patients to health care plans are too great. We have to find a way to reconcile your legitimate interest in quality and cost control with their demonstrated ability to serve vulnerable populations effectively.

And, Ms. Lore, I would like to get your specific recommendations on this. Not now but before our markup next year. So I would like you to think about it and see—and Mr. Segal as well—if you can give us any thoughts further on how to reconcile those problems.

Dr. Fishbein, you argue that the President's plan will rapidly lead to the demise of fee-for-service and PPO plans in a death spiral of adverse selection by people who use lots of medical care.

Mr. Segal, you noted that the President's bill could be improved in a number of respects but concluded that the vast majority of providers, including HMO's and PPO's, will roll with the punches and retool over time.

Since PPO's now serve, by your estimates, 90 million Americans, I am sure that a number of the members on the subcommittee would be interested in the basis for Dr. Fishbein's pessimism and your optimism. Will PPO's and fee-for-service plans survive under the President's proposal?

Dr. Fishbein?

Mr. FISHBEIN. We are an operator at New York Life of HMO's and PPO's as well as fee-for-service indemnity plans, and it is our observation in the way that PPO's operate today that they are not going to be able to be competitive with the more tightly managed HMO plans, simply in the way that they contract with providers in managed care, but even more importantly, in the fact that an HMO plan will lock people into the use of a tightly contracted network, whereas the structure of a PPO allows people to opt out and use any provider at any time.

Therefore we feel that creates the inherent anti-selection I was mentioning earlier. Those who will need more health services will tend to want to go to the plan that offers the greatest choice. Hence

they will gravitate towards the PPO and the PPO will not have the same risk group that it is covering as the more tightly managed HMO plans.

Mr. WAXMAN. Mr. Segal, do you want to comment?

Mr. SEGAL. Yes, if I may. I would like to say that the two points you raised, Mr. Chairman, are integrally together relative to the following point. My concern on the issue of the academic health centers I think is in the same direction that yours is.

We list it as a number one because it relates to the issue that the managed—if we do managed competition, which we believe is better than unmanaged competition, what we have today, you have to worry about the free rider program concept that Alain Enthoven and others in Jackson Hole have talked about, which means if you leave people out and there remain uninsured people, as the Cooper bill does, there would be the strict opportunity under strict competition to be able to say I am afraid to go after those compassionate medical centers, those inner city hospitals, those rural hospitals, because they are providing care and want to pass it on to someone else and I won't be able to use them in a competitive marketplace. That is my key concern.

Mr. WAXMAN. Thank you.

Mr. McMillan?

Mr. McMILLAN. Dr. Fishbein, I take it you believe it is possible to allow voluntary association and formation of groups out there without adverse risk selection taking place. Is an individual mandate essential to that process?

Mr. FISHBEIN. Well, we believe universal coverage is necessary. We are not necessarily taking a strong position as to what kind of mandate should lead to that, but clearly there needs to be some sort of mandate or combination of mandates that leads to universal coverage.

On the risk selection issue, though, we would propose that the same rules apply to plans both inside and outside the alliance in terms of insurance market reforms, guaranteed issue and renewability of coverage, portability, and so forth.

And we also believe, although you will hear more about this from the next panel, that it is possible to risk adjust on a group level. It is not possible, we feel, to do it on an individual level. So, if there were concerns about better risk employers choosing to go outside the alliance we feel that could be adjusted.

Mr. McMILLAN. Is it possible to set standards, call them marketing standards or whatever, that are designed to keep any group from excluding anyone to be sufficiently effective to make that work so that the group then, the size of the group becomes determined by what is economically or actuarially necessary?

Mr. FISHBEIN. The insurance market reforms that we support include guarantee issue and renewability, meaning we would take any group and an entire group. Those rules should apply equally inside and outside the alliance. A carrier or health plan should not have the option of rejecting groups or rejecting individuals within that group.

Mr. McMILLAN. I would agree with you. I think the administration plan's major short coming is in this area so that it is not going

to engender competition, it is going to engender concentration and the necessity for control.

Do you see another plan that is on the table that has features that are preferable in that respect?

Mr. FISHBEIN. Well, there are several other plans that talk about using alliances in a different way. The Chafee-Dole bill, of course, has the alliances on a voluntary basis, which is something we would support.

And again, we think that probably the best way to keep the alliances honest and to provide the best services through the alliances is to give them some competition which voluntary alliance would do. They would then have to compete with some elements of the existing competitive system.

Mr. MCMILLAN. And if in fact you can eliminate adverse selection through that process by the way you structure it, then there is really no reason to limit the size of a corporate alliance to 5,000 is there?

Mr. FISHBEIN. Well, that is correct. We would suggest that the alliances be voluntary at all sizes. And we would also suggest that the alliances be focused on the market segment where they are really needed, which would be on the small employer marketplace, not necessarily for large employers at all.

Mr. MCMILLAN. Let me direct all of your attention to the chart over here, if you can read it. Basically, in the right-hand column are figures that represent the administration's estimated cost at the present time of the standard benefit package, which is \$1,932 per individual and family coverage of \$4,360.

[The chart referred to follows:]

McWilliam #1

Premium Costs of Health Benefit Plans Annual Estimates

	1992 Employer Surveyed Costs* (FFS/HMO/PPO)	1993 Employer Surveyed Costs** (FFS/HMO/PPO)	1994 FEHB M.D. IPA Costs*** (HMO)	1994 FEHB BACE Costs*** (FFS/PPO)	1994 HSA Costs
Single Coverage	\$1,980	\$2,064	\$1,947	\$2,411	\$1,932
Family Coverage	\$4,980	\$5,448	\$5,501	\$5,706	\$4,360
Percentage above HSA Family Cost	14%	25%	26%	31%	

* 1992 HIAA Employer Survey, Composite Results

** 1993 KPMG Peat Marwick/Wayne State University Employer Survey, Composite Results

*** 1994 FEHB Guide, Combined Employer and Employee Share

Mr. McMILLAN. There have been several, I think, credible analyses of the cost of the same package by several different groups. The first column represents an HIAA 1992 employee-employer survey. The data were adjusted to the standard benefit package. The analysis is based on 1992 dollars, but what it does come down to is an estimated cost of 14 percent above the administration's estimate.

Column 2 is a 1993 KPMG Peat Marwick study, also adjusted to the standard benefit package. It is based on unadjusted 1993 dollars, but you can see that that is 25 percent above the administration's estimate.

And finally, column 4 represents that in the Federal Employees Benefit Program, which is substantially higher. There are other estimates that come in also substantially higher.

As people who are going to have to provide these benefits under a capitated plan, could you share with us to what degree your own estimates would differ from the administration's assumptions here?

Mr. SEGAL. If I might, Mr. McMillan, just to hone in directly on the point, you focus on the Federal Employees Plan and use MD-IPA where you have \$1,947 and \$5,501 which are for the FEHBP, I think it is important for you to note that in a competitive situation MD-IPA, and I am here in the National Capital Area as they are, they have different rates for different customers, and I would submit to you that if you chose them as a Federal customer under FEHBP and paid these rates you would be paying significantly higher than you would with other places where they are out there doing what Mr. Wyden talked about before, which is risk aversions, risk selections and trying to find ways to keep numbers lower, and I guess they feel they can get enough Federal employees to, in effect, pay more than other people would pay.

Mr. McMILLAN. But the averages shown here are not significantly different than the first two columns, which are national figures, not regional.

Mr. SEGAL. The point is when you do national averages, obviously, they are different region by region, as we all know, and even within a region as long as you have different employer groups paying different rates and you are experienced rating them you can go after those whose experiences are better and charge them less.

Mr. McMILLAN. But these are national averages and I am assuming whatever we do regardless of which plan we are going to have to deal with the issue of adverse selection, otherwise, nothing is going to fly.

Mr. SEGAL. No question. And that is why I think the most important thing is to include everybody in the pot under universal coverage.

Mr. McMILLAN. Could I allow the others to respond to that basic question?

Mr. WAXMAN. Yes, you may.

Mr. McMILLAN. If you would care to.

Mr. WAXMAN. Whoever wishes to respond, if you would briefly, so we can move on.

Mr. SCHLACKMAN. Only that there is some recent documentation in a piece that was produced by the health care strategies association, by Dr. Giffen, that looks at the actual projections in terms of

costs and has, I think, some strikingly different numbers in terms of cost savings associated with both HMO's and PPO's.

I think that the numbers that have been used in the past have dramatically underestimated those savings, and that may be helpful as a reference point. I can get that information to you if you would like, sir.

Mr. McMILLAN. Yes?

Ms. LORE. Mr. McMillan, just speaking very specifically for North Carolina, these numbers are very close to the cost of the Federal package in North Carolina from our organization.

Mr. McMILLAN. I see.

Mr. FISHBEIN. As you would, we would be anxious to see the assumptions that were underlying the administration's estimates that resulted in these costs.

Mr. McMILLAN. Thank you.

Mr. WAXMAN. Thank you, Mr. McMillan.

Mr. Brown?

Mr. BROWN. Thank you, Mr. Chairman.

Lots of companies around the country offer good wellness programs to their employees and in addition to the enhanced productivity and the decline in absenteeism that those programs bring, everything from weight reduction to smoking cessation to bringing physicians on premises for testing and workouts places and all that at workplaces.

I am a little concerned about the health alliances sort of losing some of that edge. Certainly the productivity will still, I mean centers for productivity, the resulting productivity will still accrue to the company, but with the health alliances in those companies of less than 5,000 that may be lost, and I am trying to figure out a way to develop a system to maintain the health care insurance part of that economic incentive in the President's plan.

Dr. Schlackman, if you would start. U.S. Healthcare apparently has done good—I understand it has done good analyses of those kinds of programs with your HMO and what you have done.

What extent do you think that employer premiums, if it were allowed in the health plan, employer premiums could be discounted for the use of a wellness work site? Do you have any figures?

Mr. SCHLACKMAN. I think as an overview, I think what we would see is the health care plans will become more responsible for the members, for the patients in that plan. That outreach to care is going to be a responsibility that is going to be placed much more in health care plans.

Now, many HMO's have taken that as an issue because the perception is that if you can create appropriate preventive care systems, not just an individual doctor doing it but systems, you can, in fact, reduce the cost of health care. Early detection as an issue, for example. So, I think that there will still be a significant incentive in this system to compete, because the competition on quality will include providing those systems, providing those plans.

Individual workplace issues for a company, for example, a health care plan would have an incentive to say these particular issues that you are addressing will be helpful and have been proven to be helpful to reduce absenteeism, as an example, and we should help you as part of the provision of care.

So I think in terms of competition it will be to the advantage of those plans that have incorporated wellness and preventive health care into their systems to be more—they will be more competitive.

Mr. BROWN. Can you also, or should you, to create sort of a synergistic effect maybe have some sort of premium discount that—if you would all speak to that—that you could offer? And if so, could you quantify what you think—

Mr. SCHLACKMAN. Well, I think the premium discount is going to be the competitive edge. If you can offer your product at a lesser price and provide, as I talked about, the quality data to say that you are doing as good a job if not better than anyone else, for the most part the informed consumer will purchase that plan.

I think the premium discount is really going to be one that says we can offer the premium for less money. We can charge less for the care because we provided this in the package and that ultimately it has greater benefit for everyone who purchases it.

I don't have a percentage number. There are a lot of numbers that have been bandied about in terms of workplace wellness programs but not a lot of data.

Mr. BROWN. Do any of the rest of you see any kind of necessity for premium discount, even segmented 5 percent for smoking cessation, 5 percent for weight reduction, 5 percent for early detection efforts? Any of you see any kind of support for that or any need for that?

Mr. Segal?

Mr. SEGAL. Yes, if I could, Mr. Brown, put it in the broader context of the first question you proposed to Dr. Schlackman, and that is that there are a number of initiatives underway by large corporations, and also medium-sized corporations, and some that are in the hundreds. And I think you are begging the question, or at least I am interpreting that, relative to the size of where people should be under some kind of alliance versus whether they could be a corporate alliance, and if the number were significantly lower, who knows what, 500, 100, there are a number of employers over a hundred who provide wellness kinds of programs, health prevention kind of programs that if they were all relieved of the authority and just said give a check to the employees I think there might be a lot of some of those kind of programs.

Mr. BROWN. Anyone else want to comment? If that is all right, Mr. Chairman?

Mr. FISHBEIN. Today, many employers even as small as, say, 100 lives are offering work site health promotion programs and very often those programs are done in conjunction, in partnership with their health insurance plan, and it is hard to imagine under an alliance structure where the employees of an employer might be in 15 different plans, how the employer could have a partnership, unless they just worked with all 15 of the plans simultaneously, which is really kind of hard to imagine happening.

Mr. BROWN. Thank you, Mr. Chairman.

Mr. WAXMAN. Did you want to respond?

Thank you, Mr. Brown.

Mr. Kreidler?

Mr. KREIDLER. Thank you, Mr. Chairman.

Ms. Lore, Dr. Fishbein says fee-for-service plans can't survive in a mandatory alliance structure, if I understood him correctly. Whether that is good news or bad news I suppose depends on your point of view.

Do you agree with Fishbein's prediction?

Ms. LORE. Well, of course, all of the—as has been said a variety of times already this morning, all of the information isn't in, but certainly we think that the alliances could certainly be structured so that there is an opportunity for fee-for-service plans to continue into future and to be successful.

In fact, we are extremely supportive of always maintaining a choice of a fee-for-service plan, at least one, in every alliance. In fact, every single fee-for-service plan that can meet all of the requirements of the alliance should be allowed to participate, and we are very supportive of that.

Mr. SCHLACKMAN. I think one of the difficulties, however, will be to provide the data that is going to be necessary to be, if you will, certified by the alliance. The data collection instruments, I think, related to what has been considered to be fragmented care in the sense of patients going in a variety of different ways and really very little opportunity to look at the quality of care delivered by individual providers in a system like that will be a limitation, and it will be difficult, I think, initially certainly, for many of the traditional, if you will, indemnity carriers to provide that kind of information that it looks like is going to be specified to be able to become certified. So that may be a limitation in terms of data.

Mr. KREIDLER. Well, I think that is probably true. That is probably the basis of the New England Journal of Medicine's report on the medical malpractice incidence in fee-for-service as opposed to managed care a couple of years ago.

Dr. Fishbein, you told Mr. McMillan that you didn't care whether the mandate is on the individual or on the employer as long as there is universal coverage. But wouldn't an individual mandate without an employer mandate lead to the same adverse selection problem for fee-for-service plans?

If your analysis is correct, don't you have to have employers to deliver groups of healthy and maybe less healthy people to the fee-for-service plans?

Mr. FISHBEIN. Yes. We would like, obviously, a cross section of risks, not any one segment of the risk. But there does need to be an employer-based market in order to support the continued existence of fee-for-service plans in order to avoid anti-selection.

Now, the mandate is not necessarily the same as how people choose their plan, obviously, but as long as there are groups going into the fee-for-service plans, then we feel it will be possible to maintain them.

Mr. KREIDLER. Would you go as far to say then that the issue of the mandate, whether it is individual or an employer, isn't a major concern to you?

Mr. FISHBEIN. I am not entirely familiar with the HIAA position on the mandate, except to say that the position is there does need to be a mandate to guarantee universal coverage, and universal coverage is fundamental to all of the principles of health care reform that we support.

Mr. KREIDLER. And that should be something that is mandatory from the standpoint that the individual or employer—that we achieve it through either the individual or through an employer mandate, but we need to achieve universal coverage?

Mr. FISHBEIN. Yes. It does appear that some sort of mandate is necessary to do that.

Mr. KREIDLER. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Kreidler.

Mr. Wyden?

Mr. WYDEN. Thank you, Mr. Chairman.

Dr. Fishbein, your statement that high cost fee-for-service plans are not going to be able to survive in the market strikes me as very startling and very significant. And I guess my question is why should the public be concerned about that if there is a vigorous set of point-of-service plans that are available which offer the efficiencies of managed care and the freedom of choice of fee-for-service at a premium that is less than the old fee-for-service plan?

Mr. FISHBEIN. The point-of-service plans as they are defined in the bill right now are really, as Ms. Lore pointed out, not what we know of as point-of-service plans today. HMO's that are offering point-of-service plans today generally offer highly restrictive out-of-network benefits. They are designed as a transition product to encourage people to enroll in an HMO, but to give them some comfort factor that occasionally they might be able to get at least some benefit for going out of network.

As the point-of-service option is defined now, it is really much more like a PPO. It is an 80/20 benefit. In fact, subject to no deductible, which is really a very rich feature, for going out of network with no restrictions. Most HMO's also have imposed gatekeeper requirements for going out of the network under the point-of-service plan.

If the point-of-service option as currently written was adopted, essentially what we would be doing is making all HMO's into a version of a fee-for-service indemnity plan, and I think you would see the cost of HMO's skyrocket relative to where they are today, because there would be very large out-of-network utilization.

Also, I think it is worth noting that about 80 percent of the population today, even though most have that choice, have chosen not to be in HMO plans and have chosen to be in either fee-for-service or PPO plans. So, I think that choice is fairly important to the population.

Mr. WYDEN. I just think what you are saying is factually incorrect. I mean we have just done a survey, for example, of the point-of-service plans across the country. There are a number of them that it is not fair to say that they are highly restrictive.

And frankly, I think that this is, you know, one of the industry's attacks on a model that really does insure that people have free choice in this country. And maybe it is going to make it tough for some of you all to run these deceptive television commercials that you have been running. But the fact of the matter is that it is a chance to ensure that consumers have some free choice.

Mr. FISHBEIN. Could I just quickly follow up on that? At New York Life we are one of the largest providers of HMO point-of-service plans nationally. We were one of the first to develop HMO

point-of-service plans and we have over 150,000 members nationwide in those programs, and our own statistics have shown that when we offer an 80/20 benefit the out of network utilization is high and the cost is significantly greater than an HMO, but when we offer a benefit such as, say, a 60 percent benefit with a fairly large deductible, then you start to get back towards the controls that HMO's can deliver.

Mr. WYDEN. Let me ask you another. You all favor these voluntary alliances there at HIAA. How would you propose that under the voluntary alliances it would be possible to protect the high risk groups and deal with some of the special concerns that they face, cultural concerns, a variety of concerns that could be injurious to them?

Mr. FISHBEIN. Well, again, we would urge that the same insurance market reforms be applied to plans both inside and outside the alliance. So, guaranteed issue of coverage to all groups and all individuals within a group, guaranteed renewability, elimination of preexisting condition, and so forth, should be applied to the plans outside as well as inside. So, any plan would be required essentially to take all comers.

Mr. WYDEN. But, you know, it seems to me that marketing can defeat those kinds of things, and I, for one, am interested in the idea of trying to make the alliances more flexible, and I think that there would be strong support for that.

But I would just hope that, you know, we not just get into a situation where we say voluntary alliances but no real standards in terms of risk adjustment and then marketing goes out to defeat.

Now, one question I might have for you, Ms. Lore. I think that you raise some valid points about point-of-service and we are interested in working with you on it. I have already indicated I think there are some good models.

But you are also saying, and a point that I really need more explanation on, that a point of service tracks people away from high cost sharing fee-for-service plans. Now, this strikes me as one of the things that could be very advantageous under a good model.

Could you explain a little bit more the concern that you have there?

Ms. LORE. If I understand you correctly, the value of point-of-service in any one marketplace, and that is the reason that Kaiser Permanente in many of our regions have embarked on an effort to develop these, is because if you want—because we do want to attract those people who have some residual hesitancy or some concern about being in a basic HMO plan.

It is not going to swing, and it is not designed to swing or attract people into our plan who are absolutely committed to a network of physicians or a free choice of physicians and hospitals that is outside of our plan. But the people that it may bring in are those folks who—within a family unit there may be one person who is committed to a physician and they have that option. So that is the—when we look at it actuarially, it is that transition over time as that person becomes more used to us.

Mr. WYDEN. Mr. Chairman, my time has expired.

I think the suggestions that you are making in terms of point-of-service are constructive and we can work with you all to try to

get those kinds of models. I would just hope that we, again, not look at the kind of argument that point-of-service is attracting people away from high cost sharing fee-for-service plans and that is a bad idea, because I think overall with a good model, there is considerable merit. I think your suggestions are constructive and we want to work with you on them.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Wyden.

I want to thank the participants of this panel. I think you have been very helpful to us. We may even have some additional questions for you for the record, and if you would respond in writing we would appreciate it.

Thank you.

We are going to take a recess now until 2 o'clock. We will reconvene in this room at 2 p.m.

[Whereupon, at 12:48 p.m., the subcommittee was recessed, to reconvene at 2 p.m., this same day.]

[The following statement was submitted:]

Impact of the Proposed American Health Security Act on Public-Sector Managed Care Plans

I am John Bluford, Executive Director of Metropolitan Health Plan (MHP), Minneapolis, Minnesota, and Administrator of Hennepin County Medical Center. I appreciate the opportunity to provide testimony regarding the impact of the American Health Security Act on public-sector, managed care programs. My comments will be limited to those concepts within the proposed Act which may have the greatest impact on organizations such as MHP. The one qualifier I would add is that definitive opinion is difficult, without knowledge of reform to be enacted with respect to the Medicaid system.

We certainly endorse the broad principles upon which this Act is based. And we endorse several of the concepts and mechanisms that are being proposed within the framework of this Act. These would include the basic tenet of the proposed reform, universal coverage, the pursuit of administrative simplicity, the funding of graduate medical education across all providers, and recognition of the roles of Essential Community Providers and Academic Medical Centers.

The first question that we have asked is, will there be a need and role for public hospital-based managed care plans? We firmly believe that there will. Public sector plans already have experience with vulnerable populations. It is the public sector plan that can best design a service to meet the needs of these special populations, and it is also the public sector plan which is best equipped to integrate the health delivery system with public health and social service systems to address quality of life situations to impact the health status of low income and vulnerable populations. A public sector plan may provide leverage for public hospitals, strengthening their position as providers and competitors.

Our greatest concern about the proposed legislation is with respect to the potential harm that could befall our public hospital system. The public system exists because of the dramatic gaps and unmet needs left by the private system. Objectives of this Act are to provide universal coverage and mainstream all Americans. There have always been, and we suspect, always will be, populations who are not covered (e.g. undocumented workers); it also remains to be seen whether the private sector will embrace the public patient, particularly in view of the proposed cap on Medicaid spending. Resource requirements to accommodate the needs of special populations are considerable (e.g. cultural differences, transportation needs, and translators) and ever-changing; the cost to the private sector and the system overall would be prohibitive if these expenditures were to be replicated at all provider sites.

We also believe the loss of disproportionate share payments would be particularly destructive to America's public hospital system. This would result in immediate, sizable shortfalls to our public

hospitals, where costs have been higher, due to the acuity rates and socioeconomic and cultural variations of the traditional patient base present at public hospitals. Under this Act, the public sector health plans will have to bid with the regional health alliance against other health plans with typically younger, healthier and homogeneous populations. In order to keep premiums competitive, the public sector plan will be forced to negotiate even lower payments to our public hospital, thus exacerbating the financial plight of the institution. The magnitude of this problem will surely increase over time for providers enrolling vulnerable populations, especially as the cap on increases in Federal spending will become more inhibiting with each passing year.

There are several other facets of this Act that we have questions about:

-Implementation of Risk Adjustment

--It is not clear how this mechanism will work. We would like to state that it is imperative that the risk adjustment formulae provide adequate reimbursement for vulnerable populations, so that the basic capitation payments need not be unnecessarily inflated.

-Implementation of Outcome Measures

--We have found this to be difficult to accomplish on a state or regional basis; this is likely to be difficult to accomplish on a national basis. We also question how these measures will be developed in a way that reflects sensitivity to the health status of the older, more acutely ill or chemically dependent populations.

-Geographic Areas Served

--A competitive health plan will need to provide excellent geographic access; in the bidding process with the alliances, health plan markets may not match the geographic boundaries of their city, district, or county, thus introducing a series of questions with regard to taxing authority, competition with the private sector, transportation constraints, etc.

In summary, we embrace the philosophical intent of the Act. However, we are concerned that people may lose sight of the importance of the public sector care system, or assume that universal coverage will remedy the financial distress experienced by many of our essential community providers. It is important that safeguards be developed which level the playing field, and enable our public system to survive and compete on an equitable basis with private sector providers and plans.

Mr. Chairman, I thank you and the Committee for the opportunity to provide input, and would be pleased to respond to any further questions that may arise.

AFTER RECESS

Mr. WAXMAN. The meeting of the subcommittee will come back to order.

On our next panel, we will hear from experts on risk adjustment as to the feasibility of adjusting health plan premiums under the President's bill so as to eliminate the incentive to avoid high risk patients.

Stanley B. Jones is a consultant in Washington, D.C., and was formerly on the staff of the Senate Labor and Human Resources Committee.

Bruce Bowen is Executive Consultant to the Internal Consulting Service of the Kaiser Foundation Health Plan in Oakland, Calif.

Alice F. Rosenblatt is the chairperson of the Risk Adjustment Work Group of the American Academy of Actuaries.

And Edward Neuschler is the Director for Policy Development and Research for the Health Insurance Association of America.

We welcome you all to our hearing today. Your prepared statements will be in the record in full. We would like to ask each of you, if you would, to limit your oral presentation to no more than 5 minutes.

Let's start with Mr. Jones.

STATEMENTS OF STANLEY B. JONES, ON BEHALF OF ROBERT WOOD JOHNSON FOUNDATION; BRUCE BOWEN, ON BEHALF OF KAISER PERMANENTE MEDICAL CARE PROGRAM; ALICE F. ROSENBLATT, CHAIRPERSON, RISK ADJUSTMENT WORK GROUP, AMERICAN ACADEMY OF ACTUARIES; AND EDWARD NEUSCHLER, DIRECTOR, POLICY DEVELOPMENT AND RESEARCH, HEALTH INSURANCE ASSOCIATION OF AMERICA

Mr. JONES. Thank you.

What I would like to do orally is just emphasize from my experience how insurers can go about risk selection, and I am only going to mention some examples that can be done, I believe, in the framework of the various market reform proposals. In other words, these are strategies that are not eliminated.

I would also say that these are things that are done presently in the market by clients I have worked with who are very sophisticated in these matters and in situations that are comparable, the nearest thing we have to an alliance kind of structure. The example of FEHBP that everyone here understands is one of the places I have done this work.

First of all, what you do is you do research. You have claims files. You look at the people who have left you this open season and the earlier open seasons and you divide them into high and low users.

You hire the best consulting firms in the country who know how to do opinion research. You talk to them 6 months before open season, during open season, after open season to ask them why did they do what they did.

The goal of the interview is to find characteristics of low users that are different from high users that you can capitalize in your marketing.

One simple characteristic discovered early in this process is that low users really don't get interested in open seasons. Most don't even crack the brochure and select among plans. Health care isn't a priority with them. The best thing you can do to keep your low users is not do anything to wake them up, not do anything to disturb them.

There are some things that disturb them. One is raising your premium a lot in a year, because these are people who feel they don't get much out of the insurance and they get angry if there is a big jump. They expect a little jump, everybody's premium goes up a little bit, but not a big jump.

So, as a strategy, if you want to market yourself among others and hold your low users, look for a gradual year-to-year strategy. Don't go low for a couple of years and then jump in order to build up reserves. If your competitor does that, let him go. It will all come home to roost when they jump in a couple of years and you will steal their low users from them.

High users are different. High users shop. They look at the brochure. They study it carefully because they have got a whole lot at stake.

On the other hand, they are slower to move. Premium increases don't bother them. They are grateful for all the coverage they have got. They tend to look more for what doctors are on your panel and whether their doctor is still there or their hospital is still there.

Therefore, there is a distinction possible. You can make a change in your panel of doctors. You can tighten it down from year to year. The low users won't mind. They don't even know who their doctor is anymore. In response to surveys, they frequently can't even remember his name. However, the high users will mind and will leave if their doctor leaves with them.

Bear in mind that we are talking about a difference in usage that is very extreme and that some 25, 30 percent of employees in big groups seldom—or don't get a claim paid in a year. A lot of people are in this low use category.

If you get enough of them, you can afford to pay for the high users you have. That is what insurance is about. And most of the work that I have seen done is, in fact, not on how to avoid high users but how to keep and attract low users. It is just the reverse of what we tend to think about in the policy process.

There are other things you can do, and I am just going to tick them off so my colleagues who have some potential answers to this problem see the magnitude of the problem.

One, you market yourself for the healthy, not the well. The image you want conveyed by your marketing department is for healthy people, even if you are good at taking care of the sick, and you had better be, because if you have them you are going to keep them. And you may want to get efficient at taking care of the chronic arthritic, but don't get known as good taking care of the chronic arthritic because they will all join you during open season. Market yourself for the healthy.

Market in media and locations that the healthy or low users favor based on your studies and opinion research. Opinion research, incidentally, the clients I have worked with have spent millions of dollars at this over the last 10 years.

Favor new or younger docs in your plan, credentialed docs. You want to be and look quality oriented, but younger docs who haven't accumulated a clientele of sick patients, because they tend to bring their patients with them into the plan, if they like the plan. You can, in fact, especially with specialists want to pursue this.

All in all there are a variety of subtle ways you can market, as rich as the way used by beer companies and cigarette companies and as hard to find, and particularly hard to find when you have many, many plans competing.

Mr. WAXMAN. Thank you very much, Mr. Jones.

[The prepared statement of Mr. Jones follows:]

STATEMENT OF STANLEY B. JONES

Mr. Chairman, My name is Stan Jones. I am a consultant on private health insurance-related policy issues whose work is funded primarily by philanthropic foundations. The views I present today are based on work done recently for the Robert Wood Johnson Foundation, and consulting work done earlier in my career for private insurance companies involved in multiple choice systems where risk selection is a major problem.

Risk selection is one of the most important barriers to reform of the health care market to encourage competition among health plans based on cost containment and quality of services. As you know, many of the proposals for reform would enable more, and perhaps all Americans to choose among competing health care plans based on their premium and the quality of their service. The idea of market reform is to encourage health plans to achieve competitive (low) prices by containing the costs of health care for their enrollees, rather than by marketing their plans to people who use relatively less health services and avoiding as possible those who use relatively more health services. Insuring people who use few services can achieve a low premium much faster than containing costs for people who use a lot of services.

It is true that market reform proposals include a number of provisions intended to ameliorate the risk selection problem. Most propose standardize benefits, as well as a process whereby plans' premiums are adjusted up or down to reflect the extent of favorable or adverse risk selection they have. Some proposals also regulate marketing practices by insurers. The Clinton plan makes it illegal for a plan to differentiate among subscribers or providers based on the perceived health care utilization of the patient. The Cooper plan monitors those joining and leaving health plans to see if there is a trend of healthy or sick people joining or leaving. Finally, some proposals introduce what they call "reinsurance pools" for people who use a lot of care. All of these provisions are relevant and move in the right directions to help an employer or alliance manager control risk selection and contain costs.

At present, however, we do not know how to ameliorate risk selection or adjust premiums for it sufficiently to prevent it from destroying competition based on cost containment and quality.

Knowledge on the subject can pretty much be summed up in the truism that healthy people choose less comprehensive benefits and sick people choose more comprehensive benefits. This generalization is what has led advocates of market reform proposals to believe standardizing benefits will go a long way toward ameliorating risk selection.

Working knowledge in the insurance industry, which has invested in research on this topic, suggests that proposals will

not adequately ameliorate the problem of risk selection. As a rule of thumb, insurers involved in multiple choice arrangements like those envisioned in health care reform hope for 20% (perhaps of the potential risk selection to be corrected by premium adjustments.

Working knowledge also suggests that an insurer who wants to achieve favorable risk selection can do so in the reformed health insurance market, in spite of the above provisions, including "reinsurance pools." An insurer in this new market, in fact, in sheer self defense against other insurers, would be obliged to be sophisticated about risk selection. For example, an insurer might:

- Invest in research on what makes healthy and sick people join or leave plans. Interview people who join and leave the plan, whose health services use is known. Find out what plan features and market images attract and repel people who use little care and people who use a lot.
- Wherever "discretionary services" are permitted by the reform legislation, offer the benefits known to attract healthier or lower utilizing subscribers.
- Invest most heavily in services attractive to the healthy. Staff these services heavily, to maintain short appointment times. These include family practice, internal medicine, pediatric and obstetric services. Staff specialty services more thinly, for longer waiting times, especially those for the chronically ill.
- Try to avoid including in your physician panel generalists and specialists who have long established practices in town, and are known to be skilled at treating the sickest and toughest cases; they may bring their patients along with them into the plan. Instead, try to include very highly credentialed physicians who are newer to the area.
- Contract with the prestigious teaching hospitals on a referral basis so you can advertise quality, but establish tough protocols for who gets referred there.
- Market so as to be seen as the plan for healthy folks. Don't advertise as the best in town at taking care of the chronically ill, even if its true.
- Within the capacity of the regulators to catch you, market and make your services most accessible to work sites and institutions where healthier people, on average, are found. Don't ever put your brochures in doctors offices or clinics. Find out what worries your low users, your healthy people, about HMOs (for example)? Structure your advertising in

ways that feed their anxiety so they stay with you. There are likely to be scores, even hundreds of health plans competing within an Alliance; there is no way they can monitor you closely enough to eliminate these practices.

- Operate an information "800 number" during open season where trained counsellors ask questions of potential subscribers that subtly tilt high users away and low users toward the plan.

Given such practices, might risk selection remain so powerful as a device for competition in the reformed health care market that health plans practice risk selection rather than cost containment and quality assurance? Could high quality health plans saddled with high utilizing subscribers be driven from the market? Could fear of risk selection force health plans annual premiums above the budgeted targets in the Clinton plan - or the informal targets in other proposals? Could subscribers be attracted into plans with good risk selection by low premiums, and away from more efficient plans, thereby increasing the costs of the whole system?

The answer is, "yes." The challenge is to develop policy tools to allow risk selection to be controlled over time. Following are some suggestions.

First, a "Manhattan project" might be launched by the president and congress to find short term working solutions to this problem. They might test available approaches, define processes of calculation and negotiation that employers and alliances might use until better tools are available - and define the research needed to develop these tools.

Then, resources need to be appropriated to fund research on a long term algorithm for adjusting for risk selection. The government and employers in general are way behind the insurers in funding such research. It has even been neglected by the Federal Employees Health Benefits Program, whose performance has been racked by risk selection for decades. Some insurers, however, have invested heavily and well; they can select an employer's risks and they will never know it is happening.

Second, we might allow alliances to use actuarial tools supplemented by business judgements and negotiation to make more extensive risk adjustments than are possible with existing algorithms. Actuaries can estimate the range of probable favorable or adverse selection among competing plans. A study of the Federal Employees Health Benefits Plan by the Library of Congress used such techniques to estimate the risk selection between FEHBP's high and standard option plans. (They differed in premium by almost 100% while their benefits differed by only 5% -

the cause is selection!). A number of national benefit consulting firms have done similar work. While the estimates of how much of the difference in premium results from risk selection and how much results from efficiency is not precise, far more agreement is possible about the range of likely risk selection than can be achieved by current algorithms. The Clinton proposal currently prohibits use of any but the nationally approved formulae for risk selection.

Third, tough penalties should be written in the law for health plans found to be discriminating among providers of care or subscribers based on likely use of care. For example, loss of certification as a health plan, freezing new marketing for a period of years, expulsion from an alliance's market, or heavy monetary penalties. Monetary penalties might also be established for opinion firms that collaborate in this discrimination by doing opinion and market research used in risk selection.

Lastly, alliances might be left free to limit the number of plans that compete in their area. No policy maker would tell General Motors they have to offer their employees every certified health plan in their areas. It would be unmanageable. Moreover, we assume G.M. might want to select the most promising plans and contract with them in the hopes of achieving more rapid progress toward cost containment and quality of care. We would expect them to use management judgement. We might allow the Alliance to manage as business people manage.

Some proposals for reform, however, require alliances to contract with all certified plans - except under dire circumstances. This is unmanageable. The current technology for measuring and managing risk selection will not permit an alliance to manage such a bewildering array of plans who are increasing their sophistication on how to achieve favorable selection.

Concluding Observations:

Not all approaches to health care reform entail all of the risks and costs of risk described above. The "single-payer" system, or "Medicare for all" approach, for example, would require far less concern with risk selection among plans.

Under the market reform approach to cost containment and quality assurance, the idea of being at risk is the core incentive to health plans. Risk selection is a flaw in this very core of the market reform approach. Risk selection must be corrected for or this approach to health reform will fail.

Mr. WAXMAN. Dr. Bowen?

STATEMENT OF BRUCE BOWEN

Mr. BOWEN. I am Bruce Bowen, and I am representing the Kaiser Permanente Medical Care Program. I want to thank you, Mr. Chairman, and members of the committee, for this opportunity to speak to you.

Competition among health plans should be based upon a combination of price, quality of care and quality of service. Selection bias hinders consumers from making informed choices among health care plans by masking differences in efficiency and creating distorted prices.

Continued selection bias will undermine multiple offerings under health care reform and could threaten the viability of alliances. Adopting standard comprehensive benefit packages, periodic open enrollment periods and community rating will reduce selection bias.

However, it is also important that multiple choice systems incorporate sound methods to ensure differences in underlying risks among health plan membership and to appropriately adjust prices based on these differences.

This can be thought of as a two-step process: risk assessment and risk adjustment. Risk assessment is the measurement of that risk, and risk adjustment is the altering of the payments to health plans in order to account for it.

The best short-term prospects, we believe, for risk assessment are approaches which use demographic information and self-reported health status to measure risk. These methods have been found to be relatively accurate for large groups, the size we would find in health alliances. They provide the best available means of measuring risk and adjusting for much of the differences in underlying risk among groups.

Methods which use clinical and diagnostic information to predict risk are being developed and are a promising longer term option. A model which uses diagnostic information to compensate plans retrospectively for especially high cost cases has been developed for New York State's small group and individual insurance pool and could also be applied on a broader scale in the short term.

Before going on, I think it is important to remind you that risk adjustment is only part of a whole package of things which are part of the administration's proposal to reduce selection bias and that all of the responsibility for dealing with the problem of selection bias can't rest on the adjustment scheme itself, but must rest on the factors which Gary Claxton outlined this morning to the committee, which include the standardized benefit package, regulation of marketing behavior or plans, a whole list of things.

When we are looking at risk assessment models, however, there are four criteria which I think it is important to take into account. First is accurate. They need not predict the individual enrollee risk, however, but should accurately predict the risk for the subgroup of people who choose each plan. Now, this is an important distinction. Many of the people who talk to you about selection bias and risk adjustment mechanisms use the standard that it must be able to predict at the individual level. That is not, we believe, nec-

essary. After all health plans have collections of individuals. It is not critical to predict which person has the heart attack, just how many heart attacks there will be in a particular group.

Of course, the best test of whether a risk assessment mechanism is accurate or not is whether it makes the health plans indifferent to the health risks that they receive.

A second test is lack of bias. A model that consistently forecast lower than expected costs for one subgroup and higher than expected costs for another would not meet the lack of bias test. For example, many models which use prior utilization to measure risk may reward plans with unnecessary utilization by systematically overpredicting the relative risks of those subgroups of enrollees who have higher utilization.

Lack of bias, particularly against efficient health plans, is more important than the accuracy of the model, although both should be considered when choosing a risk assessment model.

We believe primarily that prospective approaches are those that are critical. We have a lot to learn about measuring risk. Most insurers, health plans and actuaries have been doing it for many years. There are methods available to do it and more sophisticated models are on the way.

In summary, I think that we believe that until more accurate models are developed demographic information, self-reported health status, and a mechanism similar to New York's to compensate plans for high cost cases will provide an acceptable and accurate practical interim solution to the problem.

Mr. WAXMAN. Thank you very much, Dr. Bowen.

[Testimony resumes on p. 608.]

[The prepared statement of Mr. Bowen follows:]

TESTIMONY OF KAISER FOUNDATION HEALTH PLAN, INC.

**Before the Subcommittee on Health and the Environment
House Energy and Commerce Committee**

December 9, 1993

I. INTRODUCTION

Mr. Chairman and Members of the Subcommittee. I am Bruce Bowen, PhD, Executive Consultant for Kaiser Foundation Health Plan, Inc. I am representing the Kaiser Permanente Medical Care Program ("Kaiser Permanente"). Kaiser Permanente is a prepaid group practice program which serves over 6.5 million voluntarily enrolled members in sixteen states (California, Oregon, Washington, Hawaii, Colorado, Ohio, Texas, Maryland, Virginia, Connecticut, New York, Massachusetts, North Carolina, Georgia, Kansas, and Missouri) and the District of Columbia. It is the largest private health care program in the United States with over 90,000 employees and over 9,000 full-time equivalent contracting physicians.

Kaiser Permanente provides services in 12 operating Regions. In each Region, Kaiser Permanente is conducted by three separate organizations: Kaiser Foundation Health Plan, Inc., or one of its subsidiary Health Plans, each of which is a federally qualified health maintenance organization ("HMO"); Kaiser Foundation Hospitals ("Hospitals"); and one of 12 Permanente Medical Groups ("Medical Groups"), each of which is an independent multi-specialty group of physicians.

Kaiser Permanente accepts the responsibility of organizing and providing health care on a prepaid group practice basis. People who enroll in Kaiser Permanente receive a full range of prepaid health care services. Hospitals or Health Plan owns and operates hospitals, medical offices, laboratories, rehabilitation and mental health facilities.

We welcome the opportunity to describe how risk assessment and risk adjustment can work to reduce selection bias in a health reform program under which consumers are offered a choice of competing Health Plans.

II. THE PROBLEM OF SELECTION BIAS

Competition among Health Plans should be based on a combination of price, quality of care and quality of service. Selection bias occurs for a variety of reasons and hinders consumers from making informed choices among Health Plans by limiting Health Plan offerings, masking differences in efficiency and creating distorted prices. Continued selection bias will undermine employer-based multiple offerings and under health care

reform, and could threaten the viability of Health Alliances. Adopting standard comprehensive benefit packages, periodic open enrollment and community rating can reduce selection bias. However, it also is important that multiple choice systems incorporate sound methods to measure differences in underlying risk among Plan membership and to appropriately adjust prices (premiums or payments) based on these differences. This can be thought of as a two step process: risk assessment and risk adjustment.

Population or group based methods for risk assessment have been aggressively researched and developed in recent years. Currently, the best short term prospects for risk assessment are approaches which use demographic information and self-reported health status to measure risk. These methods have been found to be accurate for large groups (with at least 1000 individuals). They provide the best available means of measuring risk and adjusting for much of the differences in underlying risk among groups. Methods which use clinical and diagnostic information to predict risk are being developed and are a promising long term option.

A model which uses diagnostic information to compensate Plans retrospectively for especially high cost cases has been developed for New York State's small group and individual insurance pool.

III. RISK ASSESSMENT AND ADJUSTMENT

Risk assessment refers to those analytic techniques used to measure the risk in groups of people selecting different Health Plans. The goal of risk assessment is to accurately measure differences in expected costs of subgroups of a defined population in order to determine the amount by which the subgroups differ in their underlying risk. Differences in costs among Health Plans exist for a variety of reasons, including efficiency, quality, delivery system characteristics, benefits and the health of enrollees. Risk assessment is focused on the portion of the differences which is attributable to the health services needs (health) of the enrollees. There are a variety of predictive factors and statistical methods which have been used to measure the relative risk of subgroups. Most of the rest of this testimony deals with the measurement of risk.

Risk adjustment refers to techniques used to compensate for the risk differences found in the risk assessment. The goal of risk adjustment is to ensure that persons choosing and paying for health care coverage face the "correct" prices for alternative Health Plans -- prices which are free from the effects of risk differences among the Plan enrollees. This can be accomplished by adjusting the premium amount or the amount paid to Health Plans by Health Alliances so that Plans with

higher average risks receive more money than Plans with lower average risks. Either action will reduce the effect of risk on price and allow consumers to choose a Plan based on efficiency, quality and access considerations.

IV. CRITERIA FOR EVALUATING RISK ASSESSMENT METHODS

When examining risk assessment methodologies it is important to keep in mind the criteria which they should meet for acceptance.

1. *Accuracy.* How closely does the risk assessment model under consideration predict the health care service requirements (measured as costs not premiums) of groups of enrollees? As stated above, the risk, assessment model need not predict individual enrollee risk but should accurately predict the risk for the subgroup, with individual variations averaged over the group. An appropriate measure of how well a group's service requirements are predicted is the "mean prediction error".¹ Statistics such as "R-squared" and the "F-statistic" are generally examined during the development of a risk assessment model; however, they are not the best tests of a model's overall performance.

Of course the best test of all is whether the assessment and adjustment mechanism is sufficient to make Health Plans indifferent to the health risks of their enrollees and potential enrollees.

2. *Lack of Bias.* Are differences between a group's actual cost and predicted cost (based on the risk assessment model) randomly distributed or systematically skewed? For risk measurement to be useful, there should be no systematic biases in the results provided. A model that consistently forecasts lower than expected cost for one subgroup and higher than expected costs for another (e.g., male vs. female, young vs. old, members of one Plan vs. another) would not meet the lack of bias test. For example, some models which use "prior utilization" to measure risk may reward Plans with unnecessary utilization by systematically over-predicting the relative risk of those subgroups of enrollees who have higher utilization. Lack of bias, particularly bias against efficient Health Plans, is more important than the accuracy of models, although both should be considered when choosing a risk assessment model.

¹ The "mean prediction error" is measured as the summation (across groups) of the differences between actual and predicted mean costs, divided by the total number of observations: $(\sum(\text{Actual} - \text{Predicted}))/N$.

3. **Practicality/Ease of Administration.** Can the model be easily and cost-effectively applied in "real-life" situations? Goals of statistical accuracy and lack of bias must be balanced against the cost of gathering appropriate information. Thus, measures that can be easily explained, and for which data either already exist or can be gathered at modest cost, are to be favored over models which require extensive or customized information gathering.

4. **Immunity to Gaming/Manipulation.** Does the model rely on information that can be influenced or altered to gain strategic advantage by individuals or participating Plans? For risk assessment to be credible and objective, there should be no incentives for participating Plans or individuals to either alter the data reported or to benefit unfairly by practices they control.

V. PROMISING INTERIM METHODS

While there is certainly a lot to learn about measuring risk, most insurers, Health Plans, and actuaries have been doing it for many years. There are methods available to measure and adjust for risk until the development of more sophisticated and more accurate methods is completed.

Prospective/Retrospective Methods

Prospective approaches to risk adjustment are highly preferred over retrospective approaches because they create the appropriate incentives for both Plans and consumers.

Demographic Models

The best short term prospects for risk assessment are models which use demographics and self-reported health status. Demographics are the easiest to administer, the cheapest to collect, unbiased as to delivery system, and nearly impossible to game. When self-reported health status is added to demographic information, accuracy is improved at a relatively small price in terms of data collection costs² and gamability. Models based on demographics and self-reported health status explain a high proportion of the variation in risk among groups. In addition, self-reported health status does not introduce any delivery system biases.

² In one project which is currently underway, the cost of collecting a subset of the RAND-36 is about \$5 per person. In a large employer group or a Health Alliance, the data could be collected on a sample basis.

High Cost Case Pools

A diagnosis-based model which only focuses on particularly high cost cases has been developed for New York State. The New York State methodology pays Health Plans retrospectively for the high cost cases, and it sets fixed payments prospectively for a defined set of conditions. This is in contrast to traditional reinsurance pools which often just pay for claims retrospectively that are over some minimum value. These reinsurance pools tend to discourage management of the high cost care which they are reimbursing. The New York State methodology overcomes this disadvantage because the conditions are established prospectively and the payments are fixed and independent of the actual costs incurred by the Health Plan.

Self reported Health Status

Measures of health status can be added to demographic information to increase the accuracy of predictions and improve the measurement of relative risk. Health status can be ascertained either through questionnaires (self-reported) or through information such as diagnoses, treatment, prescription drug use, and past claims data.

An example of self reported health status is the set of survey questions (the RAND 36), developed by RAND during the Health Insurance Experiment³, which has been widely used to measure functional health status. The Bay Area Business Group on Health (BBGH) recently administered a shortened version of the RAND 36 to the employees of nine large companies in the San Francisco Bay Area. Their goal is to evaluate the use of this methodology for risk assessment and adjustment.⁴ Research thus far has shown that models using this information are unbiased, and tests of their accuracy are promising.⁵ The models may be susceptible to

³ Stewart, AL, Ware, JE, Brook, RH, and Devise-Avery, A. "Conceptualization of Health for Adults in the Health Insurance Study, Volume II, Physical Health in Terms of Functioning." Santa Monica, CA: the RAND Corporation. Publication No. R-1987/2-HEW, 1978.

⁴ BBGH, the Institute for Health Policy Studies of UCSF, and Kaiser Permanente have received a grant from the Robert Wood Johnson Foundation to fund an expanded version of this study. The investigators are Patricia Powers, Hal Luft, Mark Hornbrook, and Bruce Bowen.

⁵ Mark Hornbrook at the Center for Health Research has found that when using member level data, the mean prediction errors, as measured in a random half sample of the population used to construct the model (N=5000), are less than 1% of total costs when using a single equation regression model with all 36 scale items and demographic variables.

gaming and/or manipulation since they are based upon subjective responses by individuals.

VI. THE FUTURE

The future of risk assessment methodology is in diagnosis based models. However, these models have not been sufficiently developed and tested to be used for several years. Many of the current models, Ambulatory Cost Groups (ACGs⁶), Diagnostic Cost Groups (DCGs⁷), and others, were developed for other purposes or for different populations and need additional work. In addition nearly all of the diagnoses related models require data that are not routinely or uniformly collected by all Health Plans.

VII. CONCLUSION

While even more accurate models are developed, a model which combines demographic information, self-reported health status and a mechanism like New York's to compensate Plans for especially high cost cases will provide an acceptable and practical interim model for risk assessment and adjustment in Health Alliances in the near term.

Kaiser Permanente has prepared a paper on risk assessment and risk adjustment models which we are providing the Subcommittees as Exhibit 1 in our written testimony. We also are working on specific methods for adjusting premiums in Health Alliances to implement risk adjustment and will provide the Subcommittee with our work when it is completed.

⁶ Weiner, J.P., Stanfield, B.H., Stairwachs, D.M., Mumford, L.M., "Development and Application of a Population-Oriented Measure of Ambulatory Care," *Medical Care*, 29(5), May 1991.

⁷ Ash, A., Porell, F., Greenberg, L., Serwitz, E. and Beiser, A. "Adjusting Medicare Capitation Payments Using Prior Hospitalization Data," *Health Care Financing Review*, 10(4), Summer 1989, pp. 17-29.

RISK ASSESSMENT AND ADJUSTMENT

Executive Summary

The purpose of this paper is to provide input into the current debate regarding selection bias which is occurring in both the public policy and employer communities. This document briefly reviews the causes and effects of biased selection and offers a summary of the accumulated knowledge on ways to address it, focusing primarily on risk assessment and risk adjustment. It outlines both short and long term prospects for a large scale system of risk assessment and adjustment.

Selection bias has become a serious issue in situations where consumers are offered a choice of health plans. Selection bias occurs for a variety of reasons and hinders consumers from making informed choices among health plans by limiting health plan offerings, masking differences in efficiency and creating distorted prices. Ideally, competition among health plans should be based on a combination of price, quality and access to providers. When consumer prices are distorted as a result of selection bias, health plans have incentives to compete against one another for the healthiest individuals and groups. Continued selection bias will undermine employer-based multiple offerings and will threaten the viability of Health Alliances, (and possibly individual participating plans) if they are incorporated into health care reform. Therefore, it is essential that multiple choice systems incorporate sound methods to measure differences in underlying risk among plans and to appropriately adjust prices (premiums or monthly contributions) based on these differences.

Selection bias is exacerbated by common insurance practices, including benefit package designs, underwriting procedures, and pricing practices. It can be reduced by standardizing benefits and mandating consistency in underwriting and pricing. However, residual differences in the underlying risk of groups in different health plans will remain and can be addressed through risk assessment and adjustment.

Population or group based methods for risk assessment have been aggressively researched and developed in recent years. Currently, the best short term prospects for risk assessment are approaches which use demographic information and self-reported health status to measure risk. These methods have been found to be accurate for large groups (with at least 1000 individuals). They provide the best available means of measuring risk and adjusting for much of the differences in underlying risk among groups. Methods which use clinical and diagnostic information to predict risk are being developed and are a promising long term option. A model which uses diagnostic information to compensate plans retrospectively for especially high cost cases has been developed for New York State's small group and individual insurance pool, and could be applied on a broader scale in the short term.

Several risk adjustment techniques have been developed and can be used in either employer-based systems of multiple offerings or in Health Alliances. The best of these techniques are prospective in nature, removing the effects of risk from the prices consumers see when making their health plan choices. Appropriate prospective adjustments will ensure that consumers face "correct" or undistorted prices, so that they can make health plan purchasing decisions based on quality, access and price. This will also ensure that health plans that enroll higher risk populations are not penalized.

RISK ASSESSMENT AND ADJUSTMENT

Introduction

This paper provides a framework for understanding both the theory and current state-of-the-art in risk assessment and risk adjustment. Risk assessment and risk adjustment provide a means of measuring and removing the effect of the relative "healthiness" of persons choosing a health plan from the price which individual consumers see and upon which they base their purchasing decisions. Applying appropriate risk assessment and risk adjustment methods will result in consumer prices which are primarily based on differences in efficiency, quality and other attributes of the health plans, but not on the relative "health" of the persons enrolled in the plans.

These issues have become especially critical in light of the following recent developments:

- Major federal and state health care reform proposals use a framework of managed competition. Most of these proposals include as a core element the creation of large, multi-employer (or non-employer based) purchasing pools, such as Health Alliances. For these systems to operate in a manner that promotes consumer choice based on plan efficiency and quality, it is essential that sound methods of measuring differences in underlying risk among plans are used and that these risk differences are removed from the prices paid by consumers.
- Individual purchasers (e.g. employers or trusts) who offer a choice of health plans face similar issues as they evaluate the performance of competing plans. Robust tools which assess and adjust for risk not only enhance purchasers' abilities to evaluate their plans but also may guide them in their choice of benefit and contribution strategies.

This paper has the following objectives:

- To describe what is meant by "selection bias" (also "biased selection" or "risk selection");
- To identify various strategies that can help limit selection bias;
- To describe how risk assessment and risk-adjustment can measure and reduce the effects of selection bias on premium costs;
- To provide criteria for evaluating alternative risk assessment approaches;
- To describe alternative risk assessment models and evaluate them against these criteria; and,

- To illustrate and discuss the implications of alternative risk adjustment techniques.

The intent of this paper is to inform the current debate on selection issues both in the public policy and employer communities. Further information on any of these topics is available upon request.

Selection Bias: What Is It?

Selection bias or risk selection occurs whenever groups of people selecting different health plans differ in their underlying need for health care services. While there may be great individual variation in the use of medical services, selection bias occurs when the average health risk differs across plans, i.e. when the population is segmented across plans based on risk (health services needs)¹. The enrolled population with greater health care service requirements is said to be "high risk" and its chosen plan or plans to have "adverse selection." Conversely, a plan (or plans) with healthier than average enrollees and with lower health care service requirements is "low risk" and benefits from "favorable selection."

Selection bias occurs for a variety of reasons, including differences in plan benefits, premiums, choice of providers, and underwriting practices. For example, when individuals have a choice of health plans with different benefits and out-of-pocket costs, higher risk individuals generally tend to select plans with greater access to providers and with more comprehensive benefits. Conversely, lower risk individuals tend to select plans which cost less and have less rich benefits. Furthermore, some plans deliberately limit their financial exposure to high risks.

As a result of selection bias, health plans with high risk enrollees face higher costs per enrollee and thus increase their premiums. These plans become less attractive to consumers, particularly to low users and non-users of health services, independent of the plans' ability to manage utilization and unit costs. Conversely, plans with low risk enrollees are in a better position to offer lower premiums and remain attractive to consumers, particularly low users and non-users of health services, independent of the plans' cost-effectiveness. The outcome is that some plans have a competitive advantage over others, creating an "uneven playing field." Thus, plans have an incentive to compete for the healthiest individuals and make themselves unattractive to high risk individuals.

¹ "Risk" can be defined as the expected efficiently provided health care services requirements of a defined group. Risk is exogenous to the health plan or providers which individuals in the group choose. The efficient use of health care services refers to the minimum services necessary to ensure adequate access and quality care. Risk is measured as the expected per capita cost of efficiently provided health services requirements for a defined group during a defined time period. (Hornbrook, M. and Goodman, M., "Health Plan Case Mix: Definition, Measurement and Use," *Advances in Health Economics and Health Services Research: Risk Based Contributions to Private Health Insurance* 12:111-114, 1991.)

Leveling the Playing Field

In the current marketplace, health plan carriers have considerable discretion in how they select the populations they serve and how they price their benefits. Restrictive benefit package design and aggressive underwriting procedures may be used to limit plans' acceptance of high risk groups and individuals. This allows plans to keep prices relatively low, reflecting risk differences rather than efficiency differences. Shadow pricing (i.e., undercutting competitors' rates by slim margins) and rate negotiation with cost-shifting² from one group to another can also mask efficiency differences. While these practices make it difficult or impossible for plan sponsors to identify cost-effective plans, a variety of strategies can be used, in conjunction with risk assessment and adjustment, to further reduce selection bias and make the system more fair.

Standardization of benefits across plans is the most effective approach to addressing this problem. Benefit design features such as supplemental coverages, benefit exclusions, and cost sharing (e.g., coinsurance) affect the value of a benefit package to a consumer. However, many consumers have neither the necessary information nor the financial incentives to evaluate the alternatives and choose the best plan at the best price. Other consumers take advantage of benefits differences by choosing a plan which covers certain benefits that they expect to use. Thus, differences in benefit offerings confuse the choice process and invite selection bias; both consequences impede consumer-oriented market competition and invite selection bias.

Guaranteed availability, renewability and continuity of coverage, along with uniform pricing methods, are also strategies for reducing the current level of selection bias. Many health plan carriers limit their exposure to potentially high risk employers and individuals through the use of aggressive underwriting and pricing practices. In addition, many carriers try to avoid high cost cases by excluding pre-existing conditions from their coverage. These practices limit the availability of health coverage, the mobility of individuals and groups, and the choices open to health plan consumers. This restricts competition and concentrates high risk individuals and groups in plans without such practices.

Benefits standardization and consistent underwriting and pricing practices across plans will eliminate some of the conditions which encourage selection bias. However, even with these strategies, differences in the risks of enrolled persons in different plans may remain. Applying the tools of risk assessment and risk adjustment can reduce the impact of these differences and lead to market-based plan prices that primarily reflect plans' efficiencies. These approaches are described and compared in the sections below.

² Cost-shifting occurs when a health care provider increases charges to one payer in order to compensate for decreased or inadequate revenue from another payer.

Goals of Risk Assessment and Risk Adjustment

Risk assessment refers to those analytic techniques used to measure the risk in groups of people selecting different health plans. The goal of risk assessment is to accurately measure differences in expected costs of subgroups of a defined population in order to determine the amount by which the subgroups differ in their underlying risk. Differences in costs among health plans exist for a variety of reasons, including efficiency, quality, delivery system characteristics, benefits and the health of enrollees. Risk assessment is focused on the portion of the differences which is attributable to the health services needs (health) of the enrollees. There are a variety of predictive factors and statistical methods which have been used to measure the relative risk of subgroups. Several of these approaches are described and evaluated in a subsequent section.

Risk adjustment refers to techniques used to compensate for the risk differences found in the risk assessment. The goal of risk adjustment is to ensure that persons choosing and paying for health care coverage face the "correct" prices for alternative health plans -- prices which are free from the effects of risk differences among the plan enrollees. This can be accomplished by adjusting either the full premium amount or the employer and employee contributions to the premium. Either action will reduce the effect of risk on price and allow consumers to choose a plan based on efficiency, quality and access considerations.

Studies of individual level risk assessments and risk adjustments (such as Medicare's AAPCC methodologies) have raised concerns regarding the accuracy of risk assessment and its ability to fully capture differences in underlying risk. For the purposes of employer-based or Health Alliance-based risk assessment and adjustment, it is not necessary to accurately capture differences between individuals. The models used in these instances are developed to compare the average risk of subgroups rather than the risk of specific individuals within those subgroups. The balance of this paper focuses on these group-based risk assessment and adjustment models and their relative strengths and weaknesses. It is the thesis of this paper that the best of these models are sufficiently robust to capture and adjust for a large proportion of the variation between subgroups.

Criteria for Evaluating Alternative Risk Assessment Methods

This section describes four criteria that should be applied in evaluating alternative risk assessment approaches. In the next section we use these criteria to evaluate specific methods.

1. **Accuracy.** How closely does the risk assessment model under consideration predict the health care service requirements (measured as costs not premiums) of groups of enrollees? As stated above, the risk assessment model need not predict individual enrollee risk but should accurately predict the risk for the subgroup, with individual variations averaged over the group. An appropriate measure of

how well a group's service requirements are predicted is the "mean prediction error"³. Test statistics such as "R-squared" and the "F-statistic" are generally examined during the development of a risk assessment model; however, they are insufficient tests of model's overall performance.

2. **Lack of Bias.** Are differences between a group's actual cost and predicted cost (based on the risk assessment model) randomly distributed or systematically skewed? For risk measurement to be useful, there should be no systematic biases in the results provided. A model that consistently forecasts lower than expected cost for one subgroup and higher than expected costs for another (e.g., male vs. female, young vs. old, members of one plan vs. another) would not meet the lack of bias test. For example, some models which use "prior utilization" to measure risk may reward inefficient plans by systematically over-predicting the relative risk of those subgroups of enrollees who have higher utilization. Lack of bias, particularly bias against efficient health plans, is more important than the accuracy of models, although both should be considered when choosing a risk assessment model.
3. **Practicality/Ease of Administration.** Can the model be easily and cost-effectively applied in "real-life" situations? Goals of statistical accuracy and lack of bias must be balanced against the cost of gathering appropriate information. Thus, measures that can be easily explained, and for which data either already exist or can be gathered at modest cost, are to be favored over models which require extensive or customized information gathering.
4. **Immunity to Gaming/Manipulation.** Does the model rely on information that can be influenced or altered to gain strategic advantage by individuals or participating plans? For risk assessment to be credible and objective, there should be no incentives for participating plans or individuals to either alter the data reported or to benefit unfairly by practices they control.

A Survey and Evaluation of Risk Assessment Methods

In the discussion below, risk assessment models are classified by the types of predictors upon which they are based. Two broad categories of models are distinguished: (1) models using only demographic information and (2) models using measures of health status in combination with demographics. There are a number of different ways in which health status can be measured, thus the following subcategories fall under health status models: (a) models using self-reported health status; (b) models using information on diagnoses; and (c) models using prior claims information. Each type of model is briefly described

³ The "mean prediction error" is measured as the summation (across groups) of the differences between actual and predicted mean costs, divided by the total number of observations: $(\sum(\text{Actual} - \text{Predicted}))/N$.

below, and each is evaluated according to the criteria of the previous section. Table 1 also provides a summary of the models and their attributes.

The best short term prospects for risk assessment are models which use demographics and self-reported health status. Demographics are the easiest to administer, the cheapest to collect, unbiased as to delivery system, and nearly impossible to game. When self-reported health status is added to demographic information, accuracy is improved at a relatively small price in terms of data collection costs⁴ and gamability. Models based on demographics and self-reported health status explain a high proportion of the variation in risk among groups. In addition, self-reported health status does not introduce any delivery system biases. A diagnosis-based model which only focuses on particularly high cost cases has been developed for New York State and could also be implemented in the short term. Other models based on clinical information (diagnoses) are promising, but require further work before they are ready to be applied on a broad scale. Models based on prior claims are highly problematic and are not recommended.

Methods Using Demographic Variables

Demographic models are the simplest and most commonly applied tools for risk assessment. Demographic factors which are used usually include age, gender and family size (or health plan contract type). When additional information is available, factors such as salary, education, retiree status, Medicare eligibility, job classification and geographic area can also be used, making the model more complex, but also more accurate.⁵ Demographic models are generally unbiased as to delivery system, are very practical (the data for simpler models are usually readily available), and they are not subject to gaming. Their main drawback is that their accuracy declines rapidly for subgroups with fewer than one thousand individuals.

Methods Using Health Status as a Predictor

Measures of health status can be added to demographic information to increase the accuracy of predictions and improve the measurement of relative risk. Health

⁴ In one project which is currently underway, the cost of collecting a subset of the RAND-36 is about \$5 per person. In a large employer group or a Health Alliance, the data could be collected on a sample basis.

⁵ Models which use simple age-gender cells with average cost weights are also known as actuarial models and have been widely used by actuaries in the industry for risk adjustment for many years. In the past, American Airlines used an age-gender risk adjustment to adjust their contributions to health coverage. IBM has also used age-gender and geography based risk adjustments, although they are not currently doing so. Complex multi-equation conditional probability models have also been developed using demographic information. For an example, see Robinson, James, Luft, H., Gardner, L., Morrison, E. "A Method for Risk-Adjusting Employer Contributions to Competing Health Insurance Plans," *Inquiry*, 28, pp. 107-116, Summer 1991.

TABLE 1
Comparison of Risk Assessment Methods

RISK ASSESSMENT APPROACHES	ACCURACY ¹	LACK OF BIAS	PRACTICALITY/EASE OF ADMINISTRATION	IMMUNITY TO GAMING AND MANIPULATION
Demographics: Models using age, gender, etc....	Fairly accurate ²	unbiased	most practical	immune to gaming
Health Status: Self-Reported: Models using Rand-36	good - improved over demographics alone ³	unbiased	need to administer a survey	susceptible to gaming
Diagnosis: Models using ACGs	good ⁴	biased because non-discretionary use is not omitted	requires ambulatory diagnosis and treatment data	susceptible to gaming
Models using DCGs	good ⁵	small bias possible	requires inpatient data; needs further research to apply to non-Medicare population	susceptible to gaming
Models using prescription drug data	good ⁶	small bias possible	need data on prescription drug use	little gaming possible
Prior Claims: Models using the dollar value of prior claims	very good	biased because non-discretionary use is not omitted	fairly practical; simple data needs	susceptible to gaming

1. Thus far, there has not been a comprehensive comparative study of differences in accuracy for the risk assessment methods discussed here. Measures of accuracy have been calculated for each model as the models have been developed and are reported in the subsequent footnotes to this table. These measures refer only to the models individually, unless otherwise specified, and comparisons across model should be made with caution.

2. In a study of nearly 600,000 non-Medicare subscribers (plus their dependents) enrolled in Kaiser Permanente's Northern California Region, demographic risk factors were found to be good predictors of group medical care costs in large employer groups. The mean prediction error among groups with all health status factors was 8.3%. See "Predicting Medical Care Costs in Large Employer Groups," *Medical Care* 28(12):1245-53 (1990).
3. Mark Hoenbrosch and Michael Goodman at the Center for Health Research have developed a model containing demographic risk factors plus nine health status scales from the RAND-36 survey. They found that the average (absolute) prediction error when the model was applied to 25 randomly selected subgroups of an employed population was 5.1 percent. When a model containing only demographics is compared to one containing demographics and the nine RAND-36 scales, they found that the explained variance in the second model is almost five percent, compared to 1.5 percent for the demographics only. In addition, when a regression is fit between predicted and actual expense, the explained variance in the RAND-36 model is nearly four times as large as for demographics alone.

4. Weiner et al (*Medical Care* 28(5) May 1991) reported on a model using ACGs to predict ambulatory charges for an HMO population with an adjusted R^2 of .38. The same model, when used to predict total charges had an adjusted R^2 of .15.

5. Ash et al (*Health Care Financing Review* 10(4) Summer 1989) reported on two models using DCGs as predictors of annual rates of Medicare costs. A model using five DCGs had an R^2 of .017. The same model, applied to a subgroup of women aged 65-69, had a predictive ratio of 1.00 (the ratio of predicted to incurred costs).

6. Douglas Roblin of Kaiser Foundation Health Plan's Corporate Office has been working with models to predict total medical expense in 1991 for persons aged 40-65 based on risk factors in 1990. Models using demographic risk factors only have an R^2 of approximately .01, while those using demographics and prior prescription drug use (for specified medications) have an R^2 of .04-.06, depending on the model specification.

status can be ascertained either through questionnaires (self-reported) or through information such as diagnoses, treatment, prescription drug use, and past claims data.

Self-Reported Health Status

A set of survey questions (the RAND 36), developed by RAND during the Health Insurance Experiment⁶, has been widely used to measure functional health status. The Bay Area Business Group on Health (BBGH) recently administered a shortened version of the RAND 36 to the employees of nine large companies in the San Francisco Bay Area. Their goal is to evaluate the use of this methodology for risk assessment and adjustment.⁷ Research thus far has shown that models using this information are unbiased, and tests of their accuracy are promising.⁸ The models may be susceptible to gaming and/or manipulation since they are based upon subjective responses by individuals.

Diagnostic Information

There are a number of ways in which diagnostic information can be incorporated into risk assessment models. These include Ambulatory Cost Groups (ACGs⁹), Diagnostic Cost Groups (DCGs¹⁰), and methodologies using prescription drug data. As a group, these models improve upon the accuracy of demographic models and are relatively free from bias. They use clinical information which would require increased effort and expense for data collection. More research is necessary before these models can be applied on a broad scale.

ACGs were developed to estimate costs of ambulatory care, rather than the total costs of care. Models using ACGs require data on ambulatory medical care encounters (including CPT codes). Discretionary prior use was not eliminated from the estimation of ACGs, thus they suffer from the possibility of bias favoring

⁶ Stewart, AL, Ware, JE, Brook, RH, and Davies-Avery, A. "Conceptualization of Health for Adults in the Health Insurance Study, Volume II, Physical Health in Terms of Functioning." Santa Monica, CA: the RAND Corporation. Publication No. R-1987/2-HEW, 1978.

⁷ BBGH, the Institute for Health Policy Studies of UCSF, and Kaiser Permanente have submitted a grant proposal to RWJF to fund an expanded version of this study. The investigators are Patricia Powers, Hal Luft, Mark Hornbrook, and Bruce Bowen.

⁸ Mark Hornbrook at the Center for Health Research has found that when using member level data, the mean prediction errors, as measured in a random half sample of the population used to construct the model (N=5000), are less than 1% of total costs when using a single equation regression model with all 36 scale items and demographic variables.

⁹ Weiner, J.P., Stanfield, B.H., Steinwachs, D.M., Mumford, L.M., "Development and Application of a Population-Oriented Measure of Ambulatory Care," *Medical Care*, 29(5), May 1991.

¹⁰ Ash, A., Porell, F., Gruenberg, L., Sawitz, E. and Beiser, A. "Adjusting Medicare Capitation Payments Using Prior Hospitalization Data," *Health Care Financing Review*, 10(4), Summer 1989, pp. 17-29.

inefficient delivery systems. In addition, they are subject to gaming. Many HMOs (especially prepaid group practices) do not routinely collect the necessary information for ACGs, and mandating its collection would add to the cost of a risk assessment/adjustment system.

There are numerous other prior use diagnosis-based models that attempt to deal with the problem of bias against the efficient health plan. One example is DCGs, which were designed to enable HCFA to do risk adjustments for Medicare Risk contractors. DCGs are based upon hospital treatment for what have been identified as "non-discretionary" conditions using a Medicare population. Because DCGs were developed using the Medicare population, their applicability to insured persons under the age of 65 may be limited in their current form. While DCGs require considerable data, it is all contained in the Uniform Hospital Discharge Dataset which the vast majority of health plans will have available (in contrast to the ambulatory data required by ACGs.) DCGs improve the accuracy of prediction over demographics alone and are relatively difficult to game.

Other diagnoses-based models use data on prescription drugs as indicators of diagnoses and thus as predictors of costs stemming from non-discretionary medical care services. Diabetes, chronic obstructive pulmonary disease, hypertension, and coronary artery disease are examples of chronic diseases that can be identified by prescription drug use, and for which an indication of their severity can be obtained by reference to the particular drug(s) used.¹¹ Models based on prescription drug information are relatively unbiased and difficult to game. The collection of necessary data may be costly, although if prescription drugs are covered by health plans, pharmacy records on drugs dispensed are generally a good source of the necessary information.

Prior Claims Information

Claims information from the prior use of medical care services is an accurate predictor of costs and is generally readily available from claims-based systems. However, models based on this information are not recommended because they favor inefficient delivery systems and create perverse incentives. Groups with high utilization, and for which there are prior claims with a high dollar value, can be erroneously estimated to have high underlying "risk" in the models, regardless of the appropriateness of the utilization. The practical result of this type of model is that there is little incentive for health plans to improve efficiency, since inefficient services are included in the measurement of relative risk.

¹¹ Work on using prescription drug data to predict utilization and cost is in progress in the Corporate Office Department of Medical Economics and Statistics of Kaiser Foundation Health Plan, Inc. Examples include two studies by Douglas Roblin - "At Risk for Use of Hospital Services: A Study of Three Regions in Kaiser Permanente," and "Distribution of Medical Expense by Chronic Disease Status Among Older Adults in an HMO Population."

Risk-Adjustment Techniques

As stated earlier, the goal of risk adjustment is to ensure that persons choosing and paying for health coverage face the "correct" prices for alternative health plans -- prices which are free from the effects of risk differences among the plan enrollees. This section discusses several alternative risk adjustment techniques. While some of these approaches are well suited for single-employer-based health benefits programs, others are better suited for multi-employer (or non employer-based) purchasing arrangements such as Health Alliances or trusts.

These methods have several similarities:

- All make price adjustments which are based on how much the risk in a participating plan differs from the average risk in the Health Alliance or employer-sponsored health benefits program, i.e., based on "net risk."
- All use a standard dollar adjustment as a "multiplier" to correct prices, given the net risk.
- All can be made to be budget neutral to the sponsor.

However, they differ from one another in: (1) when the adjustment is made; (2) what gets adjusted; and (3) how the standard dollar multiplier is determined.

The key features of the alternative adjustment methods are listed in the following table and are discussed below.

TABLE 2
Summary of Alternative Adjustment Methods

When to adjust?	<ul style="list-style-type: none"> • Prospectively • Retrospectively
What to adjust?	<ul style="list-style-type: none"> • Plan's Premium • Sponsor's Contribution
How to adjust?	<ul style="list-style-type: none"> • <u>Performance-Based Adjustment:</u> <ul style="list-style-type: none"> - Based on the most efficient plan - Based on a selected plan • <u>Externally-Based Adjustment:</u> <ul style="list-style-type: none"> - Based on an average sponsor contribution - Based on an average per capita payment

When to Adjust: Prospective versus Retrospective Adjustment

Prospective adjustment occurs when a plan's premium or contribution is adjusted for an upcoming enrollment period based on previously obtained information about relative risk. The adjustment is made prior to individuals' enrollment in the plans. Prospective methods create appropriate incentives for plans to exercise maximum efficiency because they allow sponsors (e.g. Health Alliances or employers) to adjust prices, creating incentives for consumers to choose efficient plans.

Retrospective adjustment occurs when payments or charges are applied to plans at the end of an enrollment period. While retrospective adjustment may more accurately compensate plans for risk selection than does prospective adjustment, retrospective adjustment has no direct influence on consumer prices or incentives and therefore cannot be used to directly affect individuals' choices of plan. Retrospective methods also provide incentives for plans to game cost or utilization results in order to receive greater compensation at the period's end.

A system of risk adjustment which combines prospective and retrospective adjustments is also feasible. Plans can have premiums or contributions adjusted prospectively (prior to enrollment) and then have retrospective adjustments made at the end of the enrollment period, based on the actual experience or enrollment in each plan. This kind of system has been developed for New York State in order to compensate plans for especially high cost cases in the small group and individual enrollee pools. It may be a particularly good option in the early stages of a system incorporating risk adjustment, since it would allow plans to be compensated for risk not captured in the initial data.

What to Adjust: Premium-Based versus Contribution-Based Adjustment

The risk adjustment can be used to remove the cost of risk differences from the whole premium or from the sponsor's contribution toward the premium. If the adjustment is made to the entire premium, the sponsor should make an equal dollar contribution to each plan, and the modified premium is "passed through" to the consumer. If the sponsor's contribution is risk adjusted, the consumer's price is the unadjusted premium less the adjusted sponsor contribution. In either case, the sponsor (an employer or Health Alliance) sells plans to consumers at adjusted prices and pays health plans their quoted, unadjusted rates. A third alternative would be to pay health plans risk-adjusted per capita payments rather than quoted premiums, two examples of this are described under the heading "An Average Per Capita Payment," below.

Premium-based adjustment occurs when the program sponsor (an employer or a Health Alliance) compensates for selection bias by reducing the premiums of plans

with higher risks (so that consumers see a lower price) and increasing the premiums of plans with lower risks (so that consumers see a higher price). Under this scenario, the sponsor makes an equal dollar contribution to each plan. The consumer pays the remainder, which is the difference between the risk adjusted premium and the equal dollar (unadjusted) sponsor contribution. The sponsor collects the consumer payments and pays the health plans the amount that was set as an unadjusted premium by each plan.

Contribution-based adjustment occurs when the program sponsor compensates for selection bias by increasing its contribution toward plans with higher risks and reducing its contribution towards plans with lower risks. The consumer pays the remainder, which is the difference between the unadjusted premium and the risk-adjusted sponsor contribution. Plans are paid the unadjusted premium amount which they set.

Risk adjustment of either premiums or contributions results in equivalent employee contributions. However, in a multi-employer arrangement, in which contributions may vary by subgroup, premium-based adjustments are easier to administer. Under a single-employer system, contribution-based and premium-based adjustments are equally feasible.

The following table illustrates both premium-based and contribution-based adjustments and shows that they result in equivalent consumer prices. In both examples, the risk adjustment amounts (\$6.49, \$19.47 and -\$18.17, for plans A, B, and C respectively) are derived using the "most efficient plan" method described in the next section. These examples are discussed further in Appendix 1.A.

TABLE 3
Comparison of Premium and Contribution Adjustments

		Plan A	Plan B	Plan C
General Information				
Premium	(Hypothetical)	120.00	130.00	90.00
Unadj. Sponsor Contrib.	(Hypothetical)	90.00	90.00	90.00
Unadj. Consumer Price	(Hypothetical)	30.00	40.00	0.00
Relative Risk	(From Risk Assessment)	1.06	1.18	0.832
Adjustment Amount	(Hypothetical)	6.49	19.47	-18.17
Premium Adjustment				
Adjusted Premium	(Premium - Adjustment)	113.51	110.53	108.17
Unadj. Sponsor Contrib.	(Hypothetical)	90.00	90.00	90.00
Adj. Consumer Price	(Adj. Premium - Contrib.)	23.51	20.53	18.17
Contribution Adjustment				
Premium	(Hypothetical)	120.00	130.00	90.00
Adjusted Contribution	(Contrib. + Adjustment)	96.49	109.47	71.83
Adj. Consumer Price	(Premium - Adj. Contrib.)	23.51	20.53	18.17

How to Adjust: Performance-Based versus Externally-Based Adjustment

Several alternative methods for establishing the magnitude of the risk adjustments (given the relative risks) are described below. The general method for risk adjustment involves taking the measure of net risk for each health plan (determined by the risk assessment), applying a standard dollar amount (as a multiplier) to the net risk for each plan, and then using the results to adjust either premiums or contributions.

Performance-based adjustment refers to the use of a standard dollar amount based on the "efficiency" of one of the participating plans. When all plans share a standard benefit package, the efficiency measure of any plan is its "**average-risk rate**¹²." This is the amount that the health plan would charge if the average risk of its enrollees was equal to the average risk of the entire employer group or Health Alliance. The adjustment is made by using the average risk rate to establish a "price" for each percentage point of net risk. For example, if the average-risk rate is \$108, then the adjustment applied for each percentage point deviation from average risk is \$1.08. Thus, if the relative risk is 1.06 (6% higher than the average), then the risk adjustment is \$6.49, which is 6 times \$1.08. Two examples of this approach are discussed below and are illustrated in Table 3. These examples are discussed further in Appendix 1.B.

- *The most efficient plan* standard uses the lowest average-risk rate among the participating plans. Thus, the consumer price adjustments are limited to how much the most efficient plan would have charged for the net risk burden. **This is the preferred approach because it adjusts based on the cost of providing care efficiently and it provides the proper incentive for consumers to choose the most efficient plan.**
- *The arbitrary plan* standard uses the average-risk rate of an arbitrary plan to determine the standard dollar multiplier. This means that all other plans are adjusted by the amount that the chosen plan would charge for the net risk. Some employers choose an indemnity plan as the standard in an attempt to minimize price increases for the indemnity plan (many of which are self-insured). This approach effectively surcharges members of more efficient plans, creating additional revenue needed to maintain the viability of the indemnity plan, without requiring the indemnity to increase its price. While the stated goal of this approach is to protect the indemnity plan, using an inefficient plan as the benchmark will "over-adjust" consumer prices, and consequently, will subsidize an inefficient health care delivery system. **This approach is not recommended because it adjusts based on the cost of providing care relatively inefficiently.**

¹² The average-risk rate is calculated by dividing each plan's premium by its relative risk index.

TABLE 4
Calculation of Performance-Based Adjustment Amounts

		Plan A	Plan B	Plan C
General Information:				
Premium	(Hypothetical)	120.00	130.00	90.00
Relative Risk	(From Risk Assessment)	1.06	1.18	0.832
Average Risk Rate ¹³	(Premium + Relative Risk)	133.21	110.17	108.17
Most Efficient Plan:				
Average Risk Rate	(Plan C)	108.17	108.17	108.17
Net Risk	(Risk Index - 1)	0.06	0.18	-0.168
Adjustment Amount	(Net Risk x Avg. Risk Rate)	6.49	19.47	-18.17
Arbitrary Plan:				
Average Risk Rate	(Plan A)	113.21	113.21	113.21
Net Risk	(Risk Index - 1)	0.06	0.18	-0.168
Adjustment Amount	(Net Risk x Avg. Risk Rate)	6.79	20.38	-19.02

Externally-based adjustment occurs when the standard dollar amount chosen by the sponsor is based on an external budget constraint. Two examples are discussed below and illustrated in Appendix 1.B.

- *An average sponsor contribution* is frequently used by employers who risk adjust their contributions. The average contribution is simply the total budgeted amount available for health benefits divided by the number of covered employees. Contributions are adjusted by multiplying the relative risk index of each plan by the average contribution. While this may appear to be a very logical approach, it "under corrects" prices because the risk-adjusted amount is based on a percentage of the contribution rather than a percentage of the full premium. In addition, it does not base the adjustment amount on the cost of net risk.
- *An average per capita payment* is used when the sponsor's objective is to offer plans a risk-adjusted premium which they accept as full payment. (All other methods assume that health plans receive their quoted premiums as payment.) The adjusted premiums are calculated by multiplying a risk index by the average per person payment the sponsor chooses to pay. Under Medicare Risk contracting, an example of this approach, the Average Annual Per Capita Cost (AAPCC) is 95% of the fee-for-service cost, and is adjusted for enrollee risk and other relevant factors. This method could also be implemented under Health Alliances by having each health plan quote an average risk rate (the rate for persons or groups with average risk) which

¹³ Plan C has both the lowest premium and the lowest average risk rate. This is a coincidence of this example.

would then be charged to employer (who would pass some portion of it through to employees). After enrollment, the Health Alliance would adjust the amount paid to participating plans based on the actual risk of each plan's enrollees.

Prospective approaches to risk adjustment are highly preferred over retrospective approaches because they create the appropriate incentives for both plans and consumers. Although premium-based adjustment systems are recommended for Health Alliances, contribution-based adjustment is equally feasible for a single employer, and the effect on the prices that consumers face is the same. Performance-based adjustment using the most efficient plan as the standard is generally preferable to using an external standard, since it is less arbitrary and it provides incentives for consumers to choose efficient plans.

Examples of How Risk Adjustment Might Work

The following examples illustrate how risk adjustment might work under different circumstances. Transition issues for implementing risk adjustment under health care reform are discussed in Appendix 2. These approaches for adjusting consumer prices are preferred because they are made prospectively and are based on the "average-risk rate" of the most efficient participating plan.

Based on the results of a risk assessment, the program sponsor determines how much each plan's risk differs from the average. The sponsor then determines the lowest average-risk rate which is multiplied by each plan's net risk to derive each plan's risk adjustment amount.

- *If the sponsor is a Health Alliance or a multi-employer trust*, it adjusts the premiums by the risk adjustment amounts described above. The premiums of plans with higher than average risks will be reduced and those of plans with lower than average risks will be increased. These risk-adjusted premiums are passed on to participating employers. The employers contribute equally to each plan, an amount not to exceed the price of the lowest (risk adjusted) premium. The consumers choose among the plans facing prices which are the risk-adjusted premium less the equal dollar employer contribution. The Health Alliance collects the consumer payments and the employer contributions from all participating health plans and pays each health plan the amount they set as unadjusted premiums.
- *If the sponsor is an individual employer*, it can adjust either the premiums or its contributions. If it chooses to adjust the premiums, then it contributes equally to each plan and the employees pay the balance. If it chooses to adjust the contributions, then the employees pay the difference between the premiums and the risk-adjusted contributions. The health plans are paid the amounts they set as unadjusted premiums.

Using either approach, price differences associated with selection bias are effectively pooled across consumers; persons in high risk plans pay less and persons in low risk plans pay more than they would have without risk adjustment. The consumers face higher prices for less efficient plans, but do not pay for the risk of others in the plans. The total amount of money involved (the sum of the unadjusted premium times the number of people enrolled in each plan) is the same as before any adjustment occurs, it is just distributed differently across plans and between consumers and the sponsor. Plans are paid based on their quoted premiums, however, since consumer prices are risk adjusted, the incentive for health plans to avoid high risk groups or individuals is significantly reduced.

Appendix 1.A

Premium-Based versus Contribution-Based Adjustment Methods

This appendix compares premium-based and contribution-based risk adjustment methods. Options #1 and #2 below illustrate different ways to apply risk adjustments once they have been calculated. One method adjusts the plan premiums and the other adjusts the sponsor contributions. In either case the net consumer contributions ("consumer prices") are the same. In addition, in both cases it is assumed that health plans receive the unadjusted premium amount. The risk adjustment amounts used in these examples are \$6.49, \$19.47, and -\$18.17 for plans A, B, and C, respectively. They are derived using the "most efficient plan" method illustrated in Appendix 1.B (Option #1).

Option #1: Premium-Based Adjustment

In this example, the risk adjustments are subtracted from the unadjusted premiums of \$120, \$130, and \$90 for plans A, B, and C, respectively. This results in risk-adjusted premiums of \$113.51, \$110.53, and \$108.17 for the respective plans. The sponsor makes an equal dollar contribution of \$90 to each plan, and the consumer pays the remainder, \$23.51, \$20.53, and \$18.17 for the respective plans.

		Plan A	Plan B	Plan C
A.	Premium: Unadjusted (Hypothetical)	120.00	130.00	90.00
B.	Sponsor Contribution (Hypothetical)	90.00	90.00	90.00
C.	Consumer Price: Unadjusted (A - B)	30.00	40.00	0.00
D.	Relative Risk (From Risk Assessment)	1.06	1.18	0.832
E.	Adjustment (Appendix 1.B, #1)	6.49	19.47	-18.17
F.	Premium: Risk Adjusted (A - E)	113.51	110.53	108.17
G.	Consumer Price: Adjusted (F - B)	23.51	20.53	18.17

Option #2: Contribution-Based Adjustment

In this example, the risk adjustments are added to the unadjusted sponsor contribution of \$90. This results in the risk adjusted sponsor contributions of \$96.49, \$109.47, and \$71.83 for Plans A, B and C, respectively. The consumers pay the remainder, \$23.51, \$20.53, and \$18.17 for the respective plans.

		Plan A	Plan B	Plan C
A.	Premium (Hypothetical)	120.00	130.00	90.00
B.	Sponsor Contrib.: Unadjusted (Hypothetical)	90.00	90.00	90.00
C.	Consumer Price: Unadjusted (Hypothetical)	30.00	40.00	0.00
D.	Relative Risk (From Risk Assessment)	1.06	1.18	0.832
E.	Adjustment (Appendix 1.B, #1)	6.49	19.47	-18.17
F.	Sponsor Contrib.: Risk Adjusted (B + E)	96.49	109.47	71.83
G.	Consumer Price: Adjusted (A - F)	23.51	20.53	18.17

Appendix 1.B

Performance-Based and Externally-Based Adjustment Methods

This appendix compares performance-based and externally-based risk adjustment methods. Options #1 through #4 illustrate different ways to calculate the risk adjustments. In each example, a different standard dollar adjustment is applied to each plan's net risk to determine the plan's risk adjustment amount. "Net risk" is simply the difference between the health plan's relative risk and the average risk, based on the results of the risk assessment (e.g., $1.06 - 1.00 = 0.06$ or a net risk of 6% for Plan A).

Option #1: Most Efficient Plan

In this example, the standard is the average-risk rate of the most efficient plan. This is the premium which the most efficient plan would have charged if it had the average risk (calculated as the plan's original premium divided by the plan's relative risk value which was determined in the risk assessment.) The most efficient plan is the plan with the lowest average-risk rate, Plan C in this example. The lowest average-risk rate (\$108.17) is multiplied by each plan's net risk of 0.06, 0.18, and -0.168 for Plans A, B, and C, respectively. This results in adjustments of \$6.49, \$19.47, and -\$18.17 for these plans which can be applied to either the premium or the sponsor's contribution as described in Appendix 1.A.

			Plan A	Plan B	Plan C
A.	Premium:	(Hypothetical)	120.00	130.00	90.00
B.	Relative Risk	(From Risk Assessment)	1.06	1.18	0.832
C.	Average Risk Rate	(A ÷ B)	113.21	110.17	108.17
D.	Efficient Plan Ave. Risk Rate	(C, Plan C)	108.17	108.17	108.17
E.	Net Risk	(B - 1)	0.06	0.18	-0.168
F.	Adjustment Amount	(D x E)	6.49	19.47	-18.17

Option #2: Arbitrary Plan

In this example, the standard is the average-risk rate of an arbitrary plan. Plan A is chosen in this example. The average-risk rate is the premium which the arbitrary plan (Plan A) would have charged if it had the average risk (calculated as the plan's original premium divided by its relative risk value.) The risk adjustment amount is Plan A's average-risk rate (\$113.21) multiplied by each plan's net risk of 0.06, 0.18, and -0.168 for Plans A, B, and C, respectively. This results in adjustments of \$6.79, \$20.38, and -\$19.02 for the plans. The adjustments can be applied to either the premium or the sponsor's contribution as described in Appendix 1.A. Notice that the adjustment amounts are larger than in the previous example. This is because the standard used in this example is based on the performance of a less efficient plan, thus the "cost" per unit of risk is higher.

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		Plan A	Plan B	Plan C
A.	Premium (Hypothetical)	120.00	130.00	90.00
B.	Relative Risk (From Risk Assessment)	1.06	1.18	0.832
C.	Average Risk Rate (A ÷ B)	113.21	110.17	108.17
D.	Plan A Ave. Risk Rate (C, Plan A)	113.21	113.21	113.21
E.	Net Risk (B - 1)	0.06	0.18	-0.168
F.	Adjustment Amount (D x E)	6.79	20.38	-19.02

Option #3: Average Sponsor Contribution

In this example, the standard is the average sponsor contribution. This is calculated by dividing the total budgeted amount for health coverage made available by a particular sponsor by the number of people offered health coverage. In cases where sponsors make an equal dollar contribution to all plans, it is the amount of that contribution. In this example, the average sponsor contribution of \$90 is multiplied by the net risk assumed by each plan. This results in adjustments of \$5.40, \$16.20 and -\$15.12 for Plans A, B and C, respectively. The adjustments can be applied to either the premium or the sponsor's contribution as described in Appendix 1.A.

		Plan A	Plan B	Plan C
A.	Premium (Hypothetical)	120.00	130.00	90.00
B.	Relative Risk (From Risk Assessment)	1.06	1.18	0.832
C.	Ave. Sponsor Contribution (Hypothetical)	90.00	90.00	90.00
D.	Net Risk (B - 1)	0.06	0.18	-0.168
E.	Adjustment Amount (C x D)	5.40	16.20	-15.12

Option #4: Average Per Capita Payment

In this example, the standard is an average per capita payment, which is the amount available per person covered. A hypothetical average per capita payment of \$100 is multiplied by the net risk assumed by each plan. This results in risk-adjustments of \$6.00, \$18.00 and -\$16.80 for Plans A, B and C, respectively. The risk adjustments are applied to the average per capita payment (rather than premiums or contributions).

		Plan A	Plan B	Plan C
A.	Premium	NA	NA	NA
B.	Relative Risk (From Risk Assessment)	1.06	1.18	0.832
C.	Ave. Per Capita Payment (Hypothetical)	100.00	100.00	100.00
D.	Net Risk (B - 1)	0.06	0.18	-0.168
E.	Adjustment Amount (C x D)	6.00	18.00	-16.80

Comparison of Adjustment Amounts

A comparison of the results of the four hypothetical examples described in this appendix is given below.

	Plan A	Plan B	Plan C
Option #1: Most Efficient Plan	6.49	19.47	-18.17
Option #2: Arbitrary Plan	6.79	20.38	-19.02
Option #3: Average Sponsor Contribution	5.40	16.20	-15.12
Option #4: Average Per Capita Payment	6.00	18.00	-16.80

In the examples above, the adjustment amounts are fairly similar to one another. Nevertheless, each of these options results in different price adjustments, based upon the goals of the entity making the adjustment.

- The most efficient plan method "corrects" prices by an amount that reflects the cost of risk a relatively efficient system. By using this method, a sponsor compensates for risk differences among plans and promotes efficient systems of care.
- The arbitrary plan method over-adjusts prices since the standard is based on a relatively inefficient delivery system, thus on a higher cost per unit of risk than can be achieved by the most efficient system of care. This method does not create as much of an incentive for plans to operate more efficiently. This method may be used to "save" indemnity plans by limiting indemnity price increases for the consumer.
- The average sponsor contribution under-corrects prices because the adjustment is based on a percentage of the contribution rather than a percentage of the full premium. This method may be used by employers as an easy way to adjust prices, particularly if the employer has historically made equal dollar contributions to all plans. This standard does not reflect the cost of the net risk in each plan.
- The average per capita payment method is different from the other methods described here as it results in a risk adjusted price (per-capita payment) which is accepted by the sponsor a full payment. This standard has no relationship to the cost associated with the net risk burden.

Appendix 2

Transition Issues

There are a number of issues which will need to be considered and addressed for risk assessment and risk adjustment to be implemented under a broad health reform plan. These issues include development of appropriate data requirements and systems for data collection as well as start-up issues regarding the initial measurement of risk and development of a practical risk adjustment process.

Broad implementation of risk assessment and adjustment will require an organized system for data collection, risk measurement, determination of the appropriate risk adjusted prices and oversight of the entire process. If managed competition through Health Alliances is the reform mechanism, the Health Alliance would appropriately serve in this capacity. Under other reform mechanisms, an alternative administrator would be necessary.

While any of the risk assessment tools could be used, demographics and self-reported health status seem to be the most promising candidates for widely implemented risk assessment because they pose the lowest level of data requirements and are relatively accurate and unbiased. As more clinical data become available, a transition could be made to a disease-based measure of risk.

The First Day

Transition issues are particularly relevant on the day that the process begins. Since there will be no history under the reform mechanism, there is no simple and obvious way to establish the relative risk values or risk adjustments. One way to proceed is to base the initial risk estimates and adjustments on the current distribution of risks in health care market areas. These estimates of the existing risk distribution could be made on a sample basis if necessary.

The First Year

During the first year, periodic risk assessments and adjustments could be made based upon the most recent enrollment distributions. These could probably be made on a sample basis, either quarterly or semi-annually. At the end of the year a retrospective adjustment might be necessary, if the original estimates made for Day One were too far off. However, as discussed earlier, prospective adjustment would be the preferred method after this initial transition period.

The Second Year

Risk assessments could be made on the basis of the enrollment in health plans at the end of the third quarter of each fiscal year. Adjustments in premiums could then be made for the coming fiscal year that reflected that risk assessment.

Mr. WAXMAN. Ms. Rosenblatt?

STATEMENT OF ALICE F. ROSENBLATT

Ms. ROSENBLATT. Thank you for giving me the opportunity to speak today. I am speaking for the American Academy of Actuaries, and I am chair of the American Academy of Actuaries Risk Adjustment Work Group. Dr. Bowen is also a member of this group.

I will be discussing four main points: (1) why risk adjustment is needed, (2) the importance of risk assessment, (3) the current status of risk assessment models, and (4) our suggestions for practical short-term solutions.

Two aspects of the Health Security Act create a need for risk adjustment. These are choice and community rating. In spite of guaranteed issue and renewal requirements, health plans will attempt to avoid high risk. There is a major impact on community rates for doing this since studies have found that 4 percent of the claimants produce 50 percent of the claim costs. It is very close to a statistic that was quoted earlier this morning.

A lower community rate will increase market share and increase profit for the carriers that can avoid these risks.

Without risk adjustment, we also reward the carriers that were using medical underwriting and aggressive rating prior to reform, and we penalize the carriers that were operating with guaranteed issue and renewal and community rating prior to reform, often required by State law.

The differences due to such underwriting and rating practices can be as much as 35 to 80 percent of premium in the individual and small group markets. But choice of plan designs between fee-for-service, point-of-service and HMO-type plan designs will also cause adverse selection problems. It is likely that those who are least healthy and who have established relationships with physicians will select the plans that allow these relationships to be maintained.

There is also the potential for selection bias against health plans that contain high quality, specialized providers in their health network. Individuals who expect to need a particular type of high quality specialized care will tend to select plans that include certain specialists and high quality medical facilities in their network.

Finally, a risk adjustment mechanism may help reduce pricing uncertainty. There will be enormous pricing uncertainty originally. Carriers will need to estimate changes due to the switch from using many rating variables to community rating and will also need to account for the addition of the currently uninsured Medicaid/Medicare population and those left without insurance as carriers leave certain geographic areas.

In addition, there will be the impact of different geographic areas than those currently in use, different plan designs, and the impact of individual choice as opposed to employer choice.

The first step in doing risk adjustment is to do a risk assessment which quantifies the expected health care costs of one population compared to another. In the Health Security Act we would compare the risk profiles of the various health plans in a regional alliance with the risk profiles of the total alliance.

The next step is to use these assessments to perform risk adjustment. A risk adjustment methodology could be used to transfer payments among the various health plans in the regional alliance. A health plan with a higher than average risk population would receive a monetary payment and a health plan with a lower than average risk population would make a monetary payment.

With community rating and guaranteed issue required, these adjustments would allow premium rates to better reflect medical management and administrative differences rather than risk profile differences. Many risk assessment models exist today. The simplest model uses demographics like age and sex. More complex models use prior history. Examples of some of these models are contained in our written testimony.

The risk assessment models which use historical data are expected to be costly to implement, have timeliness problems, may reward inefficiency and inappropriate treatment of patients, and are not fully tested for accuracy and practicality for performing risk adjustment in a competitive environment. There are numerous concerns about the availability and integrity of the data.

Further complexity will be required—will be created if income and other indicators are added as is done in the Health Security Act in an attempt to make the risk adjustment mechanisms also encourage health plans to enroll low income individuals as well as transferring risk among insurers. The Academy recommends that the two needs be considered separately. Use a risk adjustment mechanism to deal with the problem of unequal distributions of risks between health plans. Use a subsidy or other type of mechanism to address the problem of access for low income individuals.

The American Academy of Actuaries' paper discusses our concerns about administrative complexity and bias of many existing models. We would be happy to provide a copy of this report for the record.

The Academy Work Group recommended a system like the one currently used in New York State as a short-term solution. This uses prospective demographic adjustments and a mandatory high cost medical condition reinsurance system.

In conclusion, we believe risk adjustment is necessary in a managed competition system with community rating. Methods exist that are suitable such as the method used in the State of New York, and the Academy would be very happy to help in both short- and long-term solution finding.

Mr. WAXMAN. Thank you very much, Ms. Rosenblatt.

[Testimony resumes on p. 622.]

[The prepared statement of Ms. Rosenblatt follows:]

AMERICAN ACADEMY OF ACTUARIES

**SUBCOMMITTEE ON
HEALTH AND ENVIRONMENT
COMMITTEE ON ENERGY AND COMMERCE
U.S. HOUSE OF REPRESENTATIVES
HEARING ON
ISSUES RELATED TO HEALTH PLANS
UNDER THE CLINTON HEALTH CARE PLAN PROPOSAL**

**TESTIMONY
BY THE
RISK ADJUSTMENT WORK GROUP
AMERICAN ACADEMY OF ACTUARIES**

**PRESENTED BY
ALICE ROSENBLATT
CHAIRPERSON, RISK ADJUSTMENT WORK GROUP**

December 9, 1993

The American Academy of Actuaries is a national organization formed in 1965 to bring together into a single entity actuaries of all specialties within the United States. In addition to setting qualification standards and standards of actuarial practice, a major purpose of the Academy is to act as the public information organization for the profession. Academy committees regularly prepare testimony for Congress, provide information to congressional staff and senior federal policy makers, comment on proposed federal regulations, and work closely with state officials on issues related to insurance.

The Academy's 18-member Risk Adjustment Work Group prepared this testimony. The group is comprised of a diverse mix of health actuaries and health policy professionals. Members include actuaries who are employed by insurance companies, national health associations and government health programs, as well as actuaries who work as independent consultants. Two health care economists and a physician also serve on the work group. In addition, the expertise of other senior health actuaries and knowledgeable professionals was drawn upon to prepare this testimony. A smaller work group produced a study paper in May 1993, Health Risk Assessment and Health Risk Adjustment--Crucial Elements in Effective Health Care Reform, which is available through the Academy.

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INTRODUCTION

Health risk assessment and risk adjustment are relevant to three separate areas addressed by the Health Security Act. The first is the mechanism through which transfers are made among health plans within a health alliance to adjust for differences in expected health care costs due to differences in the populations insured. Here the Act states that the Federal Board will develop a risk adjustment and reinsurance methodology not later than April 1, 1995.

The Health Security Act contains a second form of risk adjustment in the computation of the regional alliance inflator factors. The computation includes provision for "a method for adjusting the regional alliance inflator factor for each regional alliance in order to reflect material changes in the demographic characteristics and health status of regional alliance eligible individuals residing in the alliance area in comparison with the average change in such characteristics for such individuals residing in the United States". Ideally, if an inflator factor is used, a risk assessment mechanism will be used to make this adjustment. The third form of risk assessment in the President's proposal is necessary to perform outcome measurement to compare provider efficiency and quality.

Each of these uses of risk assessment has different objectives, places different requirements on the assessment, and may require a somewhat different methodology to meet the objective's goals.

This testimony focuses on only the first of the three types of risk assessment--the assessment of the risk differentials among health plans and the mechanism through which transfers are to be made from plans that insure lower risk to plans that insure a higher risk population. The testimony is divided into four major sections which separately address: (1) Why risk adjustment is needed when insurers in a private competitive market are required to community rate, (2) the importance of risk assessment in achieving meaningful risk adjustments, (3) the current status of risk assessment models, and (4) the Academy work group's suggestions for the most practical way to proceed with risk adjustment and community rating if the President's proposed Health Security Act of 1993 is enacted.

THE NEED FOR RISK ADJUSTMENTS UNDER THE PRESIDENT'S PROPOSAL

In an unregulated competitive private health insurance system, each insurer assesses the potential risk of individuals and groups at the time the group is insured. The insurer then charges a premium that reflects the individual or group's expected cost to the insurer. Under this financing system, older individuals, or groups dominated by such individuals, will pay higher premiums than younger individuals and groups. Similarly, those who are already known to be in poor health will pay higher rates than individuals who are currently healthy. Under this system, there is no need to make transfers among insurers to reflect differences in the risks the insurers have undertaken. These differences have already

been accounted for by differences in the premium rates the insurers have charged the higher and lower risk groups or individuals they have insured. The President's proposed Health Security Act of 1993 retains private insurers and competition among them. However, the proposal departs in two fundamental ways from the classic approach to pricing private insurance. First, the proposal requires that each insurer accept everyone who applies for coverage and guarantee the renewal of that coverage as long as the applicant is willing to pay the premium. This practice is referred to as guaranteed issue.

Second, each insurer would have to charge the same premium to everyone insured within the same geographic area. The only differences permitted in an insurer's premiums would be those reflecting differences in costs for different family types. This does not mean that all insurers would charge the same premium. For example, more efficient insurers could be expected to charge lower premiums. The practice of charging the same rate for everyone within a geographic area is called community rating.

It is possible to imagine a competitive private health insurance system based on guaranteed issue and community rating without any type of risk adjustment mechanism. But, as different as the outward appearance of that system might be, it could produce many of the results that have led to criticism of the current system.

Without risk adjustment, insurers would continue to compete based on attempts to avoid high risk individuals and groups. Four percent of the claimants of an insurance plan generate as much as 50% of the claim dollars. In the absence of risk adjustment, carriers in the regional alliance would have strong incentives to avoid attracting high risk individuals. Other factors being equal, insurers with better risks could charge lower community rates than carriers insuring high morbidity individuals and would also have the opportunity to be more profitable.

It should be expected that there will be significant differences in risk characteristics among enrollees in the various health plans during the initial few years of a reformed health care system. One reason is that, to date, different types of insurers have been subject to different regulations.

In states without small group insurance reform legislation, some carriers use medical underwriting to exclude high-risk individuals from their insurance plans. Other carriers in the same market, such as Blue Cross/Blue Shield plans, are often required by law to insure everyone who applies who can pay the premium. In addition, current rating practices differ among insurers. In a given market some insurers may be using, or be required by law to use, community rating. Other insurers in the same market charge different premiums based on a person's age, sex, location, industry, health status, health experience, and how long they have been insured.

Even in states that have enacted small group insurance reform legislation, these underwriting and rating practices may still be prevalent in the individual insurance market.

Moreover, for group insurance there is often a phase-in period for newly legislated restrictions on rating practices, and, even after full implementation, demographic rating often is permitted, as well as limited use of such rating variables as health status and health experience.

Studies have shown that if the risk profile of a carrier that has been using medical underwriting and aggressive rating is compared to a carrier that has been using guaranteed issue and community rating, there can be differences in expected morbidity costs that translate into 35% to 80% differences in premium. Thus, if the President's approach to pricing were adopted without a risk adjustment mechanism, a health plan might have the lowest rates in the regional alliance, but that could be due to the carrier's past practice of medical underwriting and aggressive rating based on risk characteristics, as opposed to more effective medical management and administrative efficiency.

A system with guaranteed issue and community rating without risk adjustment will also exacerbate the problems of adverse selection that already plague certain parts of the current private health insurance system. Under the Health Security Act, all individuals will be able to choose between fee-for-service, point of service, and HMO-type plan designs. With guaranteed issue, individual choice will assure adverse selection in the short run since those who are least healthy on the date of implementation who have established relationships with physicians they trust will select those plans that allow these relationships to be maintained. Even after initial implementation, this type of adverse selection against plans that permit the greatest choice of physicians is likely to persist. It is well known that in many areas of the country HMOs tend to attract a disproportionate share of healthy individuals. Less healthy individuals tend to prefer fee-for-service plans which offer the greatest flexibility in choice of both doctors and hospitals.

Greater opportunities for individual choice will doubtless be accompanied by greater adverse selection against plans that offer the broadest choice of medical providers. Thus, without a risk adjustment mechanism, risk selection would dominate differences in premium rates among various types of plans, and the major goal of managed competition --premium rates that reflect differences in the efficiency of delivery of medical care--would be lost.

Of equal concern is the potential for selection bias against health plans that contain high quality, specialized providers in their health networks. Individuals who expect to need a particular type of high quality, specialized care will tend to select plans that include certain specialists and high quality medical facilities in their network. Cancer patients, for instance, will select plans that include hospitals with the latest technology and physicians with distinguished reputations as oncologists. Individual choice combined with open enrollment periods will assure that adverse selection is maximized. Many high cost diseases are either chronic or require multiple years of treatment. With guaranteed issue and open enrollment, those who become ill will have an opportunity to enroll in a plan offering quality specialized care after they have been diagnosed.

Without an appropriate risk adjustment mechanism, plans with highly reputed specialists and medical facilities in their networks will be penalized because they will attract a disproportionate share of individuals requiring high cost medical care. In the absence of risk adjustment, the premiums of the plans with the best specialized medical services for one or more medical conditions would be driven up relative to plans that provide standard services. This could operate to the disadvantage of creating medical centers of excellence in certain specialized areas of medicine and could even result in plans not including certain such centers in their networks. Under the President's proposal, health plans with premiums 20% higher than the average can be barred from further participation in the alliance. Appropriate risk adjustment mechanisms, on the other hand, could both assure that such centers of excellence are preserved and could also encourage cost effective treatment at such centers.

One final reason to begin operation of a new system in the President's proposal with a risk adjustment mechanism in place is the need to reduce pricing uncertainty for insurers of all types. Although all of the ramifications of moving from the current pricing system to the one proposed in the Health Security Act cannot be anticipated, there is likely to be a good deal of price instability until the benefits of managed competition begin to work their way through the system. For insurers that have been using age and other variables to set rates, developing community rates will mean making assumptions about the distribution of risk that will remain in the insurer's risk pool. In addition, since it is expected that many insurers will leave specific markets, the insurer will need to make assumptions about the impact on the risk pool of new entrants. Then, there are the implications of adding the currently uninsured, as well as the Medicaid population and potentially even the Medicare population. There is also the impact of individual as opposed to employer choice to consider. Many individuals may select plans not currently offered by their employers. Currently, insurers charge different premiums based on geographic location. The geographic region of the health alliance may be very different than the insurer's current geographic rating areas. Carriers will also have to make adjustments for different plan designs, since the standard plans in the President's proposal differ from those most insurers currently offer.

With all of these factors coming into play, setting premiums in the short run will involve enormous uncertainty for most insurers. This uncertainty should be taken very seriously. Profit margins for health insurance are generally in the range of 2% to 4% which leaves only a small margin for error. Moreover, the short-run financial capacity of many insurers could be stretched to its limits by large numbers of new enrollees from the currently uninsured population or from the currently insured population who are abandoned when their insurer leaves the market. In such an environment, there would be a tremendous incentive for insurers to take advantage of any gaps in the regulatory structure and attempt to create new ways to avoid the worst health risks in order to assure survival, gain profitability, or simply minimize the risk of insolvency.

An appropriate risk adjustment could relieve some of the pressure of pricing uncertainty instability during the transition, but it would not solve all of the transitional problems. Insurers would still be faced with serious pricing uncertainty and initial errors in pricing might be difficult to correct since the inflator factor included in the Health Security Act would appear to prevent insurers who mistakenly underprice from recovering in the following year. In the short run at least, serious pricing and solvency concerns would remain, even with a very well designed risk adjustment mechanism. Another Academy work group is studying solvency issues that arise in the context of the President's proposal and shared its initial findings with the Commerce, Consumer Protection and Competitiveness Subcommittee in testimony on November 17. Because the regional alliance inflator factor is such a critical area and involves complex actuarial issues, the Academy has created a separate work group on this specialized area. The group will share its separate findings with this subcommittee. This Academy work group's comments are limited here to risk transfers among plans within a single health alliance.

In summary, a risk adjustment mechanism that makes appropriate transfers among health plans that undertake different levels of risk is essential to the success of managed competition as presented in the Health Security Act of 1993. First, risk adjustment is needed to protect health plans that enroll a disproportionate number of high utilizers of health care. Second, and more important from the perspective of the designers of the President's proposal, risk adjustment will tend to eliminate those differences in premiums arising solely from differences in the health risks of those insured. The remaining premium differences among insurers, then, would reflect differences in the cost and effectiveness of care, rather than whether an insurer happens to end up with a group of insureds that are, on average, higher or lower health risks.

The remainder of this testimony will discuss the general approach used to measure relative risk among insured groups, the state of the art of such measurement, the Academy work group's concerns about risk adjustment, and finally, suggestions for how, as a practical matter, risk adjustment could be dealt with most successfully under the President's proposed Health Security Act of 1993.

RISK ADJUSTMENT REQUIRES RISK ASSESSMENT

Adjusting for differences in risk among health insurers is a two-stage process. The first part of the process is assessing the health risk associated with individuals and groups, which means measuring on some objective basis the amount by which one group's expected health care costs will exceed the expected health care costs of another group. Under the Health Security Act, where health plans compete with each other within regional alliances using community rates, a risk assessment model would be used to compare the risk profile of each health plan's population with that of the total population of the regional alliance. For example, a given risk assessment model might predict that the expected health expenditures of one insurer is 20% higher than the average for the

total population of the regional health alliance. Another insurer's expenditures might be predicted to be 20% below the average for the health alliance.

Once risk assessments are done, the next step is to use these assessments to perform risk adjustment. A risk adjustment methodology could be used to transfer payments among the various health plans in the regional alliance. A health plan with a higher-than-average risk population would receive a monetary payment, and a health plan with a lower-than-average risk population would make a monetary payment. With community rating and guaranteed issue required, these adjustments would allow premium rates to better reflect medical management and administrative differences, rather than risk profile differences.

CURRENT STATUS OF RISK ASSESSMENT MODELS

There are many different methods for assigning relative risk classifications; each is distinguished by the model used to determine the risk categories. For example, a risk assessment based on self-reported health status would assign a numerical score to people based on what items they included in a report on their own health. A demographic relative risk factor would segregate individuals into risk categories on the basis of demographic factors such as age/sex or family status. A diagnostic or prior-history risk assessment method might segregate individuals into risk categories based on illness or number of hospitalizations in the previous year.

Risk assessment models can range from the very simple to very complicated. The simplest type of model for doing risk assessment would use age and sex characteristics only, since many studies show that age and sex correlate well with health care cost differentials. Other models currently being discussed include questionnaires on health status and models that use prior medical history. The prior history models are generally more complicated because of the amount of data the measurements require and the more complex interactions of the data elements.

Examples of risk assessment methods generally referenced today include:

Ambulatory Care Groups (ACGs), a model that classifies risk using age/sex and ICD-9 diagnoses assigned during ambulatory care;

Diagnostic Cost Groups (DCGs), a prior-history risk classification system that uses inpatient hospitalization data;

Payment Amount for Capitated System (PACS), a model that classifies risks using age/sex, disability status, chronicity, major diagnostic category and level of ambulatory resource use;

RAND 36--Item Health Survey 1.0, a self-reported health status measure consisting of 36 questions; and

Robinson-Luft, a model that applies a series of conditional probability regression equations to assign relative risk factors based on data from an employer's database.

Many of these risk assessment models require vast amounts of historical data on the individuals to be insured. Such methods are not without fault. They are expected to be costly to implement, have timeliness problems, may reward inefficiency and inappropriate treatment of patients, and are not, for the most part, fully tested for accuracy and practicality for performing risk adjustment in a competitive environment. A debate is anticipated over the best method to use to test the validity of these different risk assessment models. Some mistakenly believe that an adequate assessment model must predict health expenses well on an individual enrollee-by-enrollee basis. However, the intent is to remove the impact of risk selection from premiums for a health plan's whole insured population within a regional alliance. Differences in expenses among groups is what ultimately matters not which particular individual within a group becomes ill. Perhaps the best test of a risk assessment method is the willingness of health plans to participate in a new system.

The Academy work group reviewed existing risk assessment methodologies and was unable to recommend any one method. The work group strongly recommends that further research be done. The research needs to focus on the cost and administrative difficulties of using any of the methods that depend on prior history or self reported questionnaires to perform risk assessment as well as their accuracy.

A great deal of research is occurring at the current time. The Society of Actuaries (the educational and research body for life, health and pension actuaries) has established a research group to do work on risk adjustment. The Health Insurance Association of America is also performing such research as is the Bay Area Business Group on Health in California. In addition, the Academy's Work Group on Risk Adjustment is studying the results of the risk adjustment methodology currently being used in New York and will report on the New York results as information becomes available.

Much of the research that has been done on testing risk assessment methods has not tested the predictive power of a particular model in combination with a reinsurance mechanism. It is likely that with the small percentage of claimants that generate the high proportion of claims removed from a particular group of insured individuals that age and sex will account for much of the remaining variation.

INITIAL IMPLEMENTATION AND DESIGN ISSUES

An appropriate risk adjustment mechanism can be developed and implemented in the 18-month time frame stated in the President's proposal. However, any adjustment mechanism that is proposed and implemented must meet two rigorous standards.

First, the risk assessment measurement must be designed in a manner that avoids systematic understatement or overstatement of the risk associated with one or more of the factors used. Any systematic bias will result in transfers that distort premium differentials so that they are a less true representation of the differences in cost and effectiveness of care being delivered under different health plans. Such bias will also encourage insurers (and perhaps their providers) to do business in a way that takes advantage of that bias, thus exaggerating the extent to which premiums do not represent differences in the cost and effectiveness of care.

The second major criterion for a risk adjustment mechanism is that it be designed to prevent the providers from influencing the measurement by the course of care they deliver or by how they record an episode of care.

A close corollary to these first two criteria is that the data requirements for assessing risks not be unduly complex and that the adjustment methodology for making transfers be reasonably simple to administer. This is important to prevent unknown biases from creeping into the system, to limit the potential for individual insurers to manipulate the system and to avoid introducing even greater uncertainty into insurers' premium setting than the system will initially generate for other reasons.

Finally, risk adjustment should be prospective to the maximum extent possible to minimize uncertainty when insurers are setting their premiums. Prospective adjustment means that the factors used in the risk assessment must be readily available and up-to-date.

Meeting the goal of administrative simplicity will be more difficult to achieve than many may suppose. Even if a fairly simple system based on demographic adjustments plus one or two other factors were adopted, there would be complexities that would require trade-offs between accuracy in risk assessment and administrative cost. For example, there may be a need for different demographic factors for each plan design contained in the Health Security Act because medical experience by age may differ for plan designs that contain different deductibles and coinsurance features. At present, some insurance companies do not maintain data on the individuals insured, particularly for employer groups of more than 25 employees. Such employers often submit a census data statement to the insurance company that just indicates the number of individual and family units to be insured. New data requirements would be necessary for the insurance companies. (It should be noted that carriers that do not maintain such data will not be able to effectively review measurements for the purpose of managing care.)

The risk assessment methods that use prior history raise many data issues. HMO's that pay physicians capitation or have staff physicians may not currently maintain encounter data. Indemnity plan data will generally not have information on prescription drugs and information on services used that did not result in a claim submission due to the amount of the plan deductible. The data definitions between health plans can vary and there will be no prior history data on those uninsureds prior to reform. Various factors can also impact the integrity of the data. For example, the data integrity could suffer during a heavy claim backlog because of time demands placed on claim processors.

Any mechanism that is considered also needs to be able to handle frequent status changes in the population due to changes in location, family status, and employer changes, (for example, a change from an employer of smaller size in regional alliance to an employer that has a Corporate Alliance).

Privacy issues and cultural factors are also a concern. For example, if a questionnaire model is used, are individuals required to answer personal questions and how reliable will their answers be? Will certain individuals respond in a "biased" fashion due to their cultural backgrounds? Over time, it is also likely that a questionnaire-based model would be highly subject to potential gaming.

Further complexity will be created if income and other indicators are added in an attempt to make the risk adjustment mechanism also encourage health plans to enroll low-income individuals as well as transferring risks among insurers. The Academy recommends that the two needs be considered separately: use a risk adjustment mechanism to deal with the problem of unequal distributions of risks between health plans; use a subsidy or other type of mechanism to address the problem of access for low-income individuals.

The Academy agrees with the President's proposal that it may not be possible to develop an "adequate system of prospective adjustment of payment". Thus the proposal provides for a mandatory reinsurance system which may be phased in over time as adequate prospective risk adjustment systems become available. In fact, in its own report on risk adjustment, the Academy work group recommended that if a solution is needed in the short term, defined as the next 18 months, that a "non-voluntary reinsurance mechanism such as a high-cost medical condition system, with appropriate incentives for efficiently managing care be used as an interim measure . . . this mechanism will permit immediate movement toward risk adjustment without the need to build up complicated systems and procedures that may have to be discarded once a better long-term approach to risk adjustment has been determined".

However, a reinsurance mechanism raises other concerns. Such a mechanism will have to be carefully designed to avoid rewarding inefficiency. The mechanism will need to be designed in a way that avoids encouraging more treatment than necessary because of the reimbursement feature of the reinsurance mechanism.

POSSIBLE SHORT-RUN APPROACH

Some have asserted that it is not possible to design an appropriate risk assessment and accompanying adjustment methodology to accommodate a managed competition scheme that includes guaranteed issue and community rating in less than five years and, then, only if the government funds research to develop such measures. These assertions seem to contradict the very experience that has lead many to support health insurance reform.

Insurers have been severely criticized for underwriting and rating practices that allow insurers in the current environment to compete based on their ability to select risk as opposed to their ability to effectively manage medical and administrative costs. If insurers are able to effectively select good risks and avoid poor risks before insuring them, then it is reasonable that similar techniques can be used to adjust for differences in risks after they have been insured. For example, age has long been used to set premium rates and, depending upon a plan's deductibles, health expenditures for a group of males in their fifties are as much as four times health expenditures for a group of males in their twenties.

In its May 1993 report on health risk adjustment, the Academy could not recommend that any of the current risk adjustment methods under development be adopted for purposes such as those in the proposed Health Security Act of 1993. If an interim solution is needed, however, the Academy work group would propose that a mechanism similar to the one recently implemented in New York State be considered.

The State of New York passed insurance reform legislation (Small Group and Individual Insurance Reform, Chapter 501 of the Laws of 1992 and regulations NYCRR 360 and 361) that took effect April 1993. The law has a prospective risk adjustment mechanism which depends on age, sex, and family status. There is also a mandatory reinsurance mechanism for high-cost medical conditions. The types of conditions reimbursed through the high-cost medical condition reinsurance include: heart, liver, pancreas, pulmonary and bone marrow transplantation; and intensive care for neonates with low birth weight for more than 30 days. In addition, monthly payments are made for conditions such as AIDS, and specified conditions requiring ventilator dependency.

The methodology in the New York legislation tries to discourage unnecessary treatment by setting the reimbursement equal to the lesser of a fixed amount and the actual expenses incurred, where the fixed amount is low enough to encourage the management of care; i.e., carriers cannot profit from the pool, but rather will, in most cases, have some continuing financial responsibility and incentive to manage care.

It is too soon to judge how well the New York risk adjustment methodology is working. There were predictions that many carriers would stop writing business in New York State, and in fact only a limited number did. None of the major carriers in the market has yet

left the state. The Academy's Risk Adjustment Work Group has initiated a project to study the New York experience as data become available.

The New York model would require some modification before it could be adopted at the federal level. For example, the regulation requires insurers that will prospectively receive positive adjustments through the risk adjustment mechanism to build these adjustments into rates in the form of rate decreases. There is, however, no parallel requirement to increase rates for insurers that will make payouts on a prospective basis. If insurers fund their risk adjustment transfers to other insurers from their surplus assets, then the resulting premium differentials will not reflect differences in the insurers' abilities to manage medical and administrative costs. Although giving an insurer the option of not adding the money transferred to other carriers to the premium may seem like a good idea in New York State, such behavior would undermine a basic competitive premise in the President's proposal and add to the solvency risk of any insurer that chose not to pass the added cost on to those it covers.

CONCLUSION

Risk adjustment mechanisms and the risk assessments that underlie them are necessary in the context of a reformed system as defined by the Health Security Act. Proper risk assessment will do the following in a managed competition environment: enable relative comparisons of quality and efficiency of providers; accommodate adjustments for changing regional differences in morbidity over time; and permit adjustments within a regional alliance for differences in the risks insured by each participating health plan so that premiums reflect differences in the effectiveness of care rather than differences in risks.

The Health Security Act contains a provision for a risk adjustment mechanism for transfers among plans within a health alliance that states a workable solution can be found by April 1, 1995. The Academy agrees with that statement. Both the American Academy of Actuaries and the Society of Actuaries currently has work underway that will assist in the development of interim risk adjustment mechanisms, and both organizations will do all that they can to help in the development of a workable solution.

Mr. WAXMAN. Mr. Neuschler?

STATEMENT OF EDWARD NEUSCHLER

Mr. NEUSCHLER. Mr. Chairman, thank you for the opportunity to testify today. I will focus on just a few key points.

First, the Health Insurance Association of America strongly supports comprehensive health care reform, including universal coverage. In particular, we support enactment of rules that would require insurers and other health plans to take all comers, thereby guaranteeing that no one will be denied coverage or dropped from coverage based on their health status, medical condition or claims experience.

Along with other proponents of reform, we want competition among health insurers to be based on the quality of the services they provide and on how well they manage the real cost of providing medical care. But to do that we have to make sure that insurers don't benefit by being able to charge lower premiums if they enroll a healthier mix of people than their competitors, and we have to make sure that insurers aren't penalized by having to charge higher rates if they happen to get a larger than average share of people with significant medical problems. This is what a risk adjustment mechanism is expected to accomplish.

The question is whether a workable and adequate risk adjustment system can be developed. We believe the answer may depend on the environment in which the system is expected to operate.

We have had a working group of member company actuaries studying the risk adjustment issue for some months, and while their work is continuing, we have reached a few preliminary conclusions. We are confident that risk adjustment can work if most people receive their coverage as part of employment-based groups; that is, if we have a reformed insurance market in which most people's coverage is arranged directly through their employer as it is today, then we are confident that a risk adjuster can be developed and implemented that will fulfill the objectives I outlined.

Two factors contribute to this confidence. First, health care costs vary less between groups than between individuals because virtually any employer group that happens to have some unhealthy people will also have some healthy ones. Second, we have extensive experience with both rating and reinsurance approaches in the employment-based market. A risk adjustment mechanism for this environment can draw on that experience and will not have to break new ground.

On the other hand, we have very little practical experience with health insurance environments in which large pools guarantee individuals a choice among a large number of different health insurers, and the experience that is available from those environments is not reassuring. Both the Federal Employees Program and the COWPERS system have one or two participating plans that have experienced severe adverse selection, and Medicare sees the reverse side of this same problem. HCFA believes that HMO's serving Medicare patients have been benefiting from favorable selection, leaving the worst risks in the traditional program.

Understandably, people who are older or who have existing health problems want to keep seeing the physicians with whom

they have already established satisfactory relationships. Therefore they don't want to join plans that limit their choice of doctor or that make them pay much more to see an out-of-plan doctor. As a result, insurers that offer complete free choice of doctors or at least good coverage for out-of-plan services get a higher proportion of sicker and costlier people than other plans.

This is one kind of problem risk adjustment is intended to solve and it may prove possible to develop a risk adjuster that will work in an individual choice environment. But after reviewing the research available to date, we are not yet convinced.

In this kind of environment we are dealing with more than civil demographic differences that can be easily adjusted for. What makes the problem more difficult is that each individual will always know more about his or her own health situation than can be determined by outsiders who must rely on objective external observations about the person.

If virtually everyone is required to get their health insurance through large regional health alliances as the administration proposes, the continued existence of health plans offering relatively free choice of provider will depend critically on the existence of a workable risk adjuster that can adequately compensate for the bias selection that is certain to result in that environment. If no such risk adjuster is available, free choice plans will be unaffordable for many Americans unless the ability to arrange coverage outside the health alliances is maintained.

As you no doubt know, we at the Health Insurance Association think there are many other convincing reasons why health alliances should not be made the only way Americans can arrange health coverage.

Mr. Chairman, our actuarially work group is continuing to work on possible risk adjustment models and to look at data and run them through a demonstration program, and I hope we will be able to come back early next year and tell you what we have found. In particular, we hope to be able to demonstrate at least that risk adjustment can deal with potential selection problems when coverage is based on employer-sponsored groups.

Be happy to answer any questions you may have.

Mr. WAXMAN. Thank you very much.

[Testimony resumes on p. 657.]

[The prepared statement of Mr. Neuschler follows:]

Edward Neuschler

Director of Policy Development and Research
Health Insurance Association of America (HIAA)

Mr. Chairman and members of the subcommittee, I am Ed Neuschler, Director of Policy Development and Research, Health Insurance Association of America (HIAA). I am here today representing the Health Insurance Association of America (HIAA) in response to your request for comments on issues relating to risk selection and risk adjustment by health plans. HIAA is a trade association of about 270 commercial insurers covering approximately 65 million Americans.

The focus of my testimony today is on health risk adjusters: what they are, why they are needed, what the current state of the art is, and how well they work with or without health insurance purchasing cooperatives.

Risk Adjustment and Risk Adjusters Defined

According to the American Academy of Actuaries, a risk adjustment mechanism is a two-step process of risk assessment (determining the relative health risk of individuals compared to an average) and risk adjustment (transferring money among carriers based on the composite risk assessment of all individuals each carrier insures).

The term, risk adjuster, is used by some researchers and actuaries to refer to the risk classification method used to assign relative risk values to individuals, but the American

Academy of Actuaries considers this to be part of the risk assessment step of a risk adjustment mechanism.

The term risk adjuster is also used generically to refer to the entire risk adjustment mechanism (risk assessment and risk adjustment). Risk adjuster is used in this context throughout this testimony, and will be used interchangeably with the term, risk adjustment mechanism.

Need for Risk Adjustment

Congress, in reforming the health care system of today, will need to include some method of risk adjustment, i.e., some way of matching premium revenues received by health insurers with the underlying risk of the population they are enrolling. The American Academy of Actuaries has said that "under most reform proposals, some form of health risk adjustment will be required to allow reform strategies to work effectively." We agree. This is because all reform proposals, including HIAA's own Vision for Reform, call for open enrollment and rating restrictions to some degree or another. Such proposals dissolve the link between the premium the carrier is allowed to charge and the costs the carrier expects to incur in serving a particular individual or group.

In the current market, insurers adjust premiums up front to reflect the relative risk of insureds (see Chart 1). Individual

insureds are placed in broad pools with other individuals with similar risk characteristics, called risk classes. All of the individuals in a particular risk class are then charged the same premium based upon the average claims cost of all individuals in the class. Individuals in certain risk classes may be called low risk--such as a risk class of young nonsmokers--because the average claims cost of individuals in this class is less than the average across all risk classes. Individuals in other risk classes may be called high risk--such as older smokers--because their average claims cost is higher than the average across all risk classes.

Thus, a low risk person might have claims cost and premiums that are half of the average claims cost and premiums across all risk classes. A high risk person might have claims cost and premiums that are three times the average--as illustrated in Chart 1.

If health plans are required to charge the same premium to everyone they cover, each insured person would pay a premium equal to the insurer's average premium across all risk classes, say \$300 a month for a single person (see Chart 2). This average for all insureds is much closer to the average for low risk insureds because there are more low risk insureds than high risk insureds. However, just equalizing everyone's premium would do nothing to the underlying claims cost. A low risk person would still cost the insurer (or, have expected claims cost of) about half of the average while a high risk person would have expected

claims cost of three times the average. This situation creates strong incentives for carriers to avoid high risk persons.

Chart 3 shows how health risk adjusters help to solve this problem. After risk adjusters are implemented, the sum of the expected claims cost and the risk adjustment transfer payment will be approximately the same for individuals in each risk class. Hence, the insurer becomes indifferent to selling coverage to a low risk or a high risk person. The insurer's revenues (premiums plus transfers) would be back in line with the underlying risk of the population it is enrolling--an important factor for the solvency of any insurer.

The State of the Art

The goals of risk adjustment in health care reform proposals can be reduced to two basic objectives: (1) elimination or reduction of risk selection by carriers and (2) elimination or reduction of any adverse financial impact on carriers receiving a disproportionate share of high-risk insureds.

The first objective is to make sure that carriers compete on the basis of administrative and medical efficiency and not on the basis of how well they can select healthy lives. HIAA firmly supports this objective.

The second objective is to protect carriers and their policyholders against the threat of insolvency when open enrollment and rating restrictions combine to prevent the carrier from charging a premium that reflects the actuarial cost of the insureds it covers.

In addition, the magnitude of risk adjustment required is directly related to the severity of rating restrictions in the system. For example, the magnitude and accuracy of risk adjustments would have to be greater in a pure community-rated system than in an age-rated (community rated by class) system.

From the perspective of some policymakers, the goal of risk adjustment is to reduce premium differentials. From our perspective, this can be taken too far, i.e., the risk adjustment mechanism should not strive to eliminate all differences in premium or health risk from the system. If all health risk were removed from the system by risk adjusters, there would be no incentive for carriers and insureds to manage or reduce risks--such as by obtaining preventive care or pursuing healthy lifestyles. Insureds should still have incentives for pursuing healthy lifestyle choices, and carriers should retain the responsibility for managing the remaining risk in the system.

Policymakers have also suggested that a risk adjustment mechanism could be designed that would facilitate subsidizing low-income and needy individuals. While we believe such subsidies are a

necessary part of reform, they should not be a part of the risk adjustment mechanism. Including them would cloud understanding of the highly technical risk adjustment mechanism and potentially undermine its primary objectives. In short, risk adjustment mechanisms should not try to further social policy goals unrelated to health risk adjustment.

Risk adjustment mechanisms should apply across-the-board to all health plans, within the applicable market (i.e., specific geographic area and designated employer size), regardless of the mechanism through which the coverage is obtained. That is, there should be a level playing field and the mechanism should be unbiased.

With the discussion of health insurance purchasing pools, another question arises that is affected by the current state of the art for risk adjusters. When employees, rather than employer groups, get to choose which health plan the employee will join, the precision of the risk adjustment mechanism has to be much greater than when the employer chooses a health plan that all of its employees join. An example will help to demonstrate why this is so.

Chart 4 shows the claims experience of individuals within a typical employer group. The annual claims cost per individual ranges from about \$57,000 to \$0 with about 20 percent of the individuals incurring 80 percent of the total claims cost.

Chart 5 shows a comparable distribution of the average claims cost per person for a number of employer groups, ranging from about \$1700 to about \$2900 annually.

These two charts illustrate that the variance in cost is much greater for individuals than for employer groups. It is much easier for a risk adjuster to compensate for the variance in costs between employer groups of insureds, where the highest average rate is less than two times the lowest average rate, than it is for a risk adjuster to compensate for the variance in costs between individuals, where the highest rate is over \$50,000 and the lowest rate is \$0.

We believe that risk adjustment is well enough understood today and is similar enough to current rating and reinsurance approaches to make us reasonably certain that blocks of employer-sponsored plans could be risk-adjusted to the extent necessary to preclude risk selection by carriers. That is, a risk adjuster could be developed and implemented which would effectively eliminate both the financial rewards for risk selection and the negative impact of adverse selection. That is, any potential financial advantage would be reduced to a low enough level that the cost of trying to select risks would outweigh any remaining financial advantage. This result can be achieved because, within almost any employer group, healthy lives will be combined with unhealthy lives. This co-mingling of health status reduces the variability of costs per insured between different employer

groups and, therefore, between health plans as well.

Furthermore, since these individuals have not joined together just to purchase health insurance, the carrier can estimate their costs as if they were random draws from a large population with similar characteristics.

The same statement cannot be made with assurance for insured populations where the choice of plan is made on an individual basis. If employees get to pick, as individuals, which health plan they want, their knowledge of their own underlying health situation is likely to influence their choice of plan.

Individuals with 2 or 3 chronic conditions, for example, are more likely to choose a conventional fee-for-service plan, to guarantee that they will be able to see all the specialists with whom they have already established relationships. Individuals with few health problems are more likely to choose a plan with a limited network of providers, especially if it's less expensive. This leads to a situation in which plans that offer greater choice of provider tend to get sicker enrollees than the average. As a result, their premiums are higher and they are less affordable. Over time, their remaining healthy enrollees leave and the plan's premium becomes ever higher as the risk profile of its enrollees worsens. Eventually, the plan is priced out of the market.

Theoretically, an effective risk adjustment mechanism would adjust for this biased selection and stop this so-called "death

spiral". As a practical matter, however, there is no current research or evidence to assure us that a risk adjustment mechanism can be developed and realistically implemented that would be accurate enough to protect carriers from the adverse selection that can result within a purchasing cooperative where individuals are allowed to choose any plan they want.

In order to address these and other issues, further research should be conducted in order to identify those risk assessment and risk adjustment methods that can effectively deal with the concerns of insureds, carriers and regulators.

Because of the far-reaching impact these risk adjusters would have on premiums and the solvency of health plans, HIAA is conducting a broad-based demonstration to evaluate the efficacy of different types of risk adjusters using actual member company data. We hope to have the demonstration project completed and a report available early next year.

How Well Risk Adjusters Work With and Without Purchasing Cooperatives

Just as pure community rating (which we do not support) makes all insureds pay an average premium, health risk adjusters move everyone towards an ideal of having, in effect, the same average claims cost. They do not make each insured's claims cost exactly equal to the average, however, because there will still be

differences in provider practice patterns and efficiency (how well a plan manages the health care of its members and its overhead costs).

Health risk adjusters accomplish their task by transferring funds between health plans based on the health status of plan members. A simple risk adjuster based on the three risk classes shown in charts 1, 2 and 3 illustrates how. Let's assume that the premiums and costs illustrated in these three charts represent the average costs and premiums for a typical health plan in the community for each of the three risk classes: low, average and high risk.

For every high-risk insured with expected claims cost equal to 300% of the average claims cost of all individuals in the community, the health plan would receive from the health risk adjustment pool a fixed amount of \$522 a month. When the health plan uses this fixed payment to reduce its expected cost of \$783 a month to \$261 a month, the new expected cost to the health plan of covering this high risk person is reduced to the average cost in the community (assuming a perfect risk adjuster that fully adjusts to the average cost and assuming a perfectly efficient plan). Thus, the risk adjustment transfer effectively eliminates any incentive for the plan to avoid covering this high risk individual.

Likewise, for every low-risk insured with expected claims cost equal to 60% of the average cost of all individuals in the community, the health plan would pay the health risk adjustment pool a fixed amount of \$104 a month. When the health plan adds this fixed payment to its expected claims cost of \$157 a month, the new expected cost to the health plan of covering this low risk person (\$261 a month) equals the average cost in the community.

Transfers to the pool for low risk members and transfers from the pool for high risk members are fixed by the methodology. For every low risk person in the community, the same \$104 risk transfer payment is made to the risk adjustment pool by his or her health plan - regardless of which plan the person joins. That is, each plan says \$104 for every low risk person that joins the plan. Likewise, each plan receives \$522 for every high risk person it covers.

This also holds true whether the health plan sells directly to employers or through a purchasing cooperative. A health plan operating within a health insurance purchasing cooperative would receive \$522 each month for every high risk insured. Any health plan operating outside a purchasing cooperative would also receive \$522 each month for every one of its high risk insureds. Similarly, every health plan, whether inside a purchasing cooperative or not, would pay \$104 a month to the pool for every low risk person it insured. In other words, the risk adjustment

pooling mechanism works the same way no matter which plan the individual joins and regardless of whether a plan participates in a purchasing pool or sells directly to employers and individuals.

Thus, mandatory purchasing alliances are not necessary in order for health risk adjustment mechanisms to work. However, I want to emphasize again that, so far, we are confident that risk adjusters can counteract biased selection only when plans are enrolling employment-based groups, not when they are enrolling individuals who are allowed to choose any plan they want. As mentioned earlier, a much more sophisticated and/or accurate risk adjuster is required to solve this problem than to develop a risk adjuster that works in a market where employer-groups choose the plan.

Summary

If we want insurers to compete on their ability to manage the cost of providing needed care, rather than on their ability to select the healthiest risks -- and we do -- then we have to make sure that the premiums insurers charge reflect only their administrative efficiency and their effectiveness in managing care - not variations in the underlying risk of the people they have enrolled.

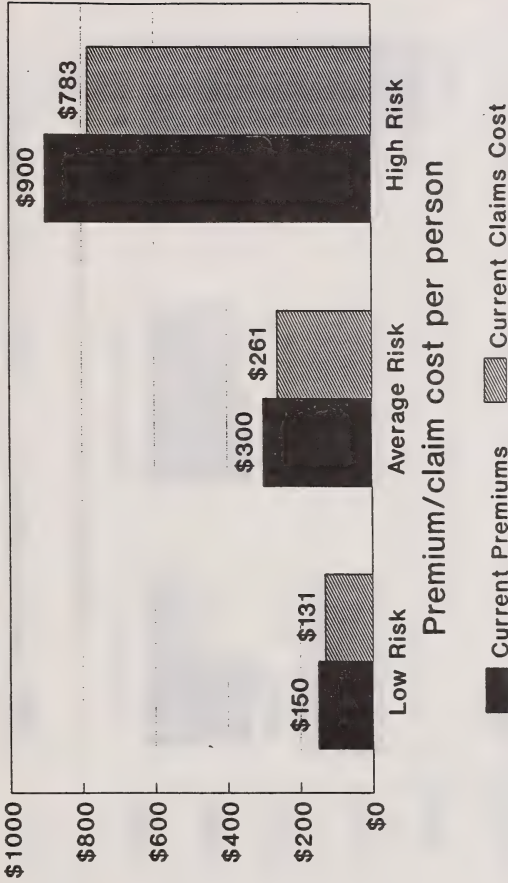
This is what a risk adjustment mechanism is supposed to do. Whether a successful risk adjustment mechanism can be developed remains to be seen. Various methods have been proposed, but none has yet been tested for this purpose on an employed population. The HIAA has a group of actuaries looking at the problem, and they tell us that much depends on whether insurers are enrolling groups or individuals.

The variation in health care costs from individual to individual in a given year is extremely large. The variation among employer groups, even relatively small ones, is much less. Thus, stability and predictability in the health insurance system are enhanced when most citizens obtain health coverage as part of an employment-based group, rather than as individuals. This is one of the many reasons why we oppose requiring virtually all employers to arrange health coverage through purchasing pools. Because risk characteristics of employer groups are better known and can be estimated with readily available demographic data, we are confident that it is possible to develop a risk adjustment mechanism that will work adequately if insurers are enrolling employment-based groups. We have no such confidence about a purchasing pool environment in which individuals choose their own health plans.

In conclusion, I want to emphasize that we support much more of the President's plan than we oppose. We are striving to be a responsible participant in the national health care debate and want to work with the Administration and the Congress to develop national reform which achieves universal coverage, promotes individual responsibility and cost containment, preserves choice and maintains the quality of our health care system.

Current Premiums-vs-Claims Cost*

Average Monthly Premiums and Cost

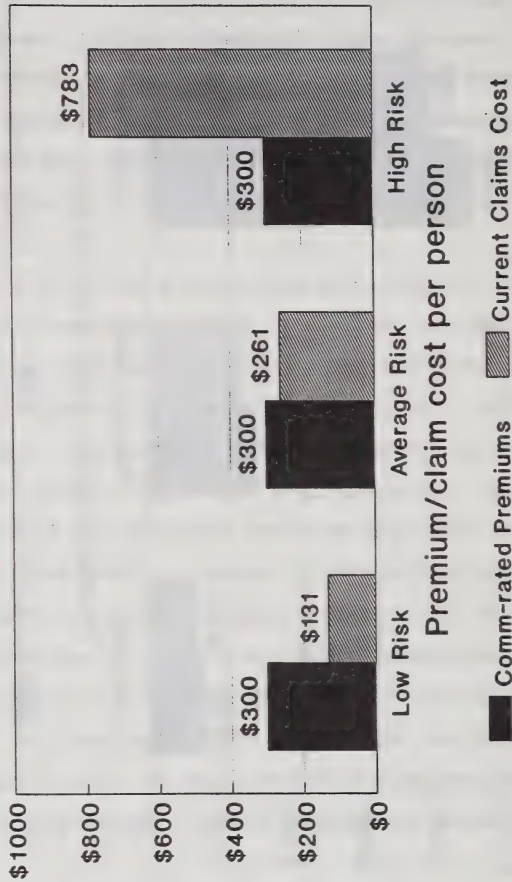


* Illustrative values for one health plan for insureds with single coverage
Source: Health Ins Assoc of America

Chart 1

Community-Rated Premiums-vs-Claims*

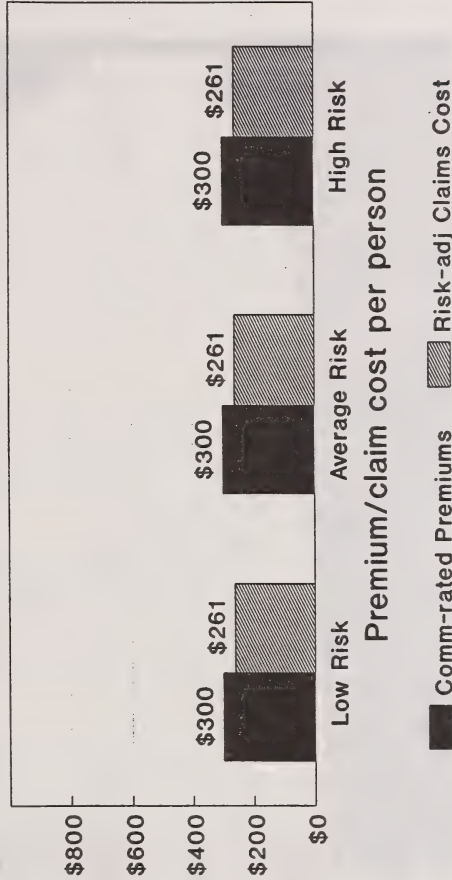
Average Monthly Premiums and Cost



* Illustrative values for one health plan for insureds with single coverage
Source: Health Ins Assoc of America

Chart 2

Community-Rated Premiums-vs- Risk-Adjusted Claims Cost* Average Monthly Premiums and Cost



* Illustrative values for one health plan for insureds with single coverage
Source: Health Ins Assoc of America

Chart 3

Claims Experience of Individuals in a Typical Employer Group

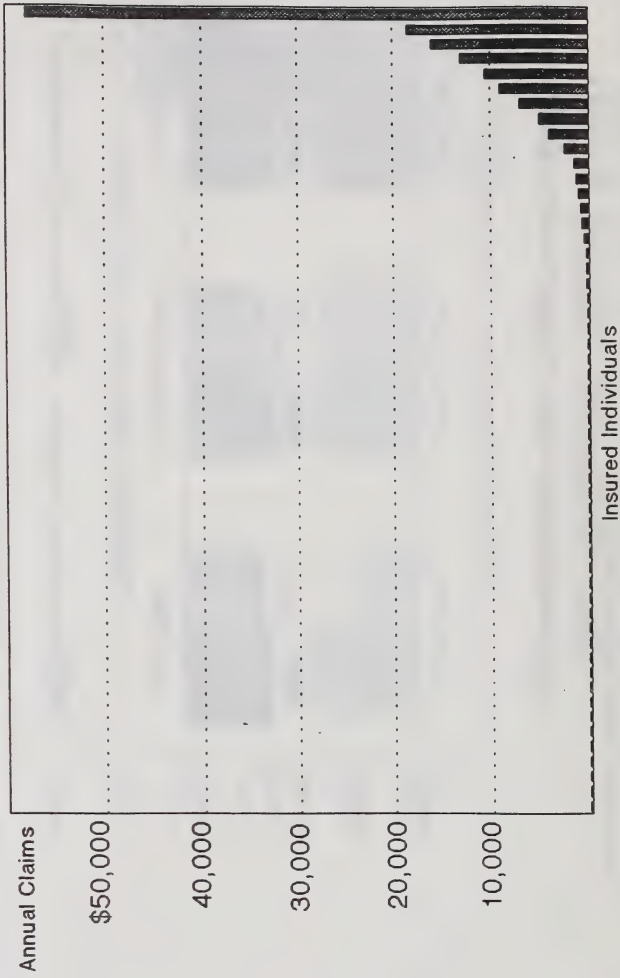


Chart 4

Average Annual Claims = \$2000

Source: Mutual of Omaha

Average Claims for a Number of Employer Groups

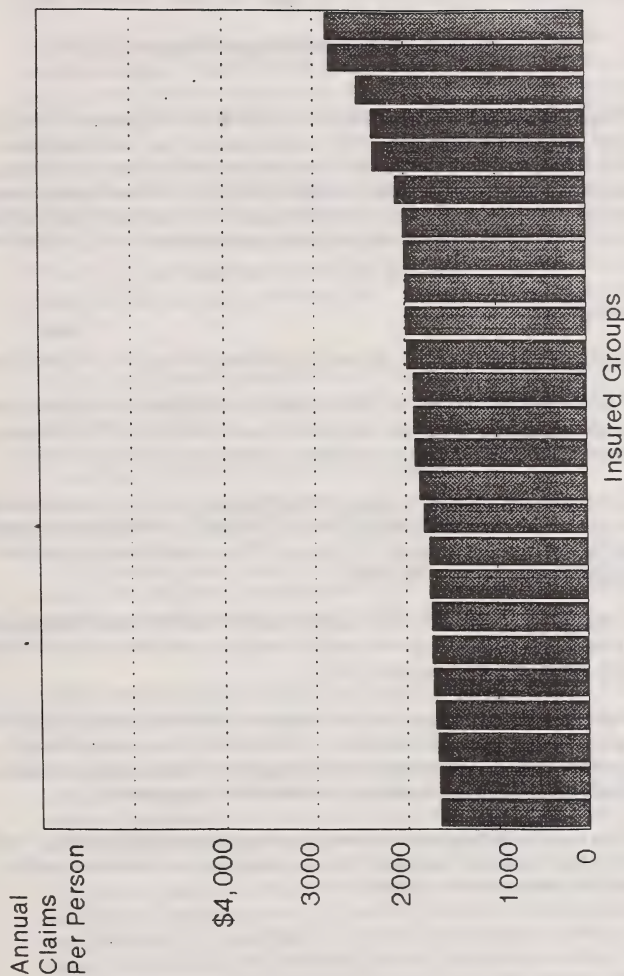


Chart 5

Average Group Claims per person = \$2000

Source: Mutual of Omaha

How Risk Adjustment Might Work in a Voluntary Purchasing Pool Environment

Steps in the Risk Adjustment Process

The following scenario illustrates one way in which "risk adjustment" ¹ might work across all health plans in a market area. The example assumes that small employers may purchase basic coverage directly from health plans, or they may arrange for coverage through a purchasing pool (regional health alliance or HIPC). All health plans, whether selling to individual employees through a purchasing pool or to employers outside the pool, are subject to uniform rating requirements and other regulations pertaining to basic benefit coverage.

Additional assumptions include:

- ▶ Employers and employees are required to purchase coverage for the basic plan.
- ▶ Each health plan/carrier quotes a flat community-rated premium for basic benefit coverage which is the price each individual enrollee must pay. The community-rated premium could alternatively be calculated per employee (primary insured).
- ▶ For simplicity, we describe an annual risk adjustment process, assuming there is no entry into or exit from plans during the year. In reality, the adjustment process would take place more frequently to address differing enrollment periods and other enrollment changes during the year.
- ▶ This example addresses only risk selection issues within the employed population. The subsidies necessary to provide health coverage to non-employed individuals and families are essentially a separate issue.

In this example, the entity overseeing the risk adjustment process is simply called the "risk adjustment administrator" (RA Administrator). The function of overseeing the risk adjustment process could be performed by a state agency or board, a state or regional purchasing pool, a private-sector enterprise, or some other organization.

We first describe the sequence of events in the risk adjustment process. We then present a simplified numerical example of the rate adjustment and revenue transfer calculations which are part of the process.

¹ In the context of health reform, the term "risk adjustment" refers to a process of transferring (redistributing) premium income among health plans in a market area. Risk adjustment is needed in a reformed insurance market whenever rating restrictions prevent plans from charging premiums that reflect the expected costs the plans will incur.

Sequence of Events

Step 1 Health plans/carriers register with the RA Administrator.

- Several months before enrollment begins, all health plans/carriers who wish to sell coverage for basic benefits in the market area in the coming year must register with the RA Administrator, and must indicate whether they plan to sell this coverage through the purchasing pool or directly to small employer groups.
- As a condition, they must agree to all market rules, including participating in the risk-adjustment process (discussed earlier).

Step 2 The RA Administrator provides the information each health plan/carrier needs to develop its "standardized" community rate.

The RA Administrator provides each plan/carrier with 3 standard pieces of information which the administrator will use in calculating revenue transfer amounts for each plan:

- definitions of the risk classification categories;
- the "relative risk factors" for each risk category; and
- the reference premium amount upon which the transfer amounts will be based. The reference premium could be last year's average premium in the community trended forward, or any another designated amount.

Step 3 Each health plan/carrier develops its standardized community rate for the coming year.

- Development of the plan's/carrier's "standardized" community rate starts with the community rate it would charge in the absence of a risk adjustment process. Adjustments are then made considering expected transfer payments and other contingencies associated with risk adjustment.
- Plans are free to use whatever method they choose to develop their standardized community rate. A plan may choose to use the information supplied by the RA Administrator (step 2) to calculate its expected transfer amount, and to adjust its community rate by the transfer amount. The rate would be adjusted upward if the plan/carrier expects to have to pay into the transfer pool, and downward if it expects to receive money from the transfer pool.

- Each plan/carrier may choose to further adjust its rate for pricing uncertainties associated with the risk adjustment process.
- The end result is the plan's "standardized" community rate, the rate enrollees (or their employers) will actually be charged for enrollment in the plan.

Step 4 RA Administrator publishes rates.

- The plans report their standardized community rates to the RA Administrator.
- The RA Administrator publishes the rates well before enrollment begins, together with information about whether the plan/carrier is marketing inside or outside the purchasing pool.

Step 5 Enrollment.

- Health plans/carriers market either directly to small employers, or to individual employees purchasing through the pool.
- Small employers evaluate options and decide to purchase coverage directly, or through the purchasing pool.
- Individual employees (inside) and small employers (outside) choose their preferred plans.

Step 6 Health plans/carriers report actual enrollment data to the RA Administrator.

- Plans/carriers selling inside the purchasing pool (HIPC) receive enrollment information from the pool administrator.
- All plans/carriers report to RA Administrator their total enrollment and distribution of enrollees by risk category.

Step 7 RA Administrator calculates transfer amounts and administers revenue transfers.

- The RA Administrator calculates each plan's/carrier's revenue transfer amount, based on the plan's/carrier's actual enrollment, the relative risk factors and the reference premium.
- For plans/carriers which must pay into the transfer pool (plans/carriers with actual relative risk lower than the community average), the RA Administrator bills the plan/carrier for the transfer amount.
- The RA Administrator pays out the transfer amounts to the plans/ carriers which receive money from the transfer pool (plans/carrier which have actual relative risk greater than the community average).
- Theoretically, the risk adjustment process aims for a zero balance in the transfer pool in each period -- transfers in should equal the transfers out. In practice, neither the plans/carriers nor the RA Administrator have perfect knowledge, and there may be changes in total enrollment and enrollee distribution by risk class in the community during the year. To ensure that the transfer pool has sufficient funds (remains solvent), the transfer amounts could be adjusted, or another source of funds could be tapped to create a reserve upon which the transfer pool could draw if needed.

Attached (Attachment B) is a simplified numerical example of how this risk adjustment process would work in practice.

How Risk Adjustment Might Work in a Voluntary Purchasing Pool Environment

A Simplified Numerical Example

NOTE: This example is intended solely to illustrate the steps in the risk adjustment process described above. Other approaches to risk adjustment are possible. Further, the risk categories and assigned relative risk factors used here are arbitrary and purely illustrative.

Step 1 Health plans/carriers register with the RA Administrator.

Three health plans/carriers register with the RA Administrator: Plan A, Plan B, and Plan C. These are the only plans/carriers in the community (offering basic benefit coverage), and together they cover all 20,000 members of the community.

Step 2 The RA Administrator provides the information each health plan/carrier needs to standardize its community rate.

A. Risk categories.

The RA Administrator tells the health plans/carriers there are three risk categories:

Category Definitions

Category 1

Category 2

Category 3

B. Relative risk factors.

The RA Administrator tells the plans/carriers the relative risk factors for each category:

Relative Risk Factors

Category 1 - 0.6

Category 2 - 0.8

Category 3 - 1.6

C. Reference premium.

The RA Administrator tells the plans/carriers that the reference premium for calculating transfer amounts is \$200. The reference premium can be fixed at any reasonable amount. One choice could be the RA Administrator's estimate of last year's average cost per person for the community as a whole, trended forward. Another option is an estimate of the average cost per person of the more efficient plans/carriers.

Step 3 Each health plan/carrier develops its standardized community rate for the coming year.

NOTE: Plans will in fact, use whatever method they choose to develop their "standardized community rate," which is the rate enrollees or their employers will actually be charged for enrollment in the plan. (We ignore here any mark-up the HIPC might add to fund its operations.) This example illustrates one way the plans might approach developing their standardized community rates.

A. Expected enrollment.

The three plans/carriers expect the following enrollment:

Expected 1994 Enrollment (number of enrollees)				
Plan	Category 1	Category 2	Category 3	Total
A	2000	5000	1000	8000
B	1000	3000	2000	6000
C	1000	2000	3000	6000
Whole Community	4000	10,000	6000	20,000

B. Unadjusted flat community rate.

Based on plan historical experience, expected medical inflation, etc, plan/carrier actuaries calculate the flat community rate the plan/carrier would charge in the absence of rating restrictions for the expected enrollment (expected risks). We call this the "unadjusted" community rate.

Unadjusted Community Rate

Plan A - \$190

Plan B - \$210

Plan C - \$240

C. Plan/carrier expected relative risk (average risk relative to whole community)

Based on the enrollee category relative risk factors supplied by the RA Administrator, plan/carrier actuaries calculate the plan's expected relative risk. The average risk for the whole community is 1.00.

The expected relative risk is a weighted average of the category relative risk factors, where the weights are the proportion of enrollees expected in each category.

$$\text{Plan A: } (2000 (0.6) + 5000 (0.8) + 1000 (1.6)) / 8000 = 0.85000$$

$$\text{Plan B: } (1000 (0.6) + 3000 (0.8) + 2000 (1.6)) / 6000 = 1.03333^*$$

$$\text{Plan C: } (1000 (0.6) + 2000 (0.8) + 3000 (1.6)) / 6000 = 1.16667$$

* rounded

Expected Relative Risk

Plan A - 0.85000

Plan B - 1.03333

Plan C - 1.16667

D. Expected transfer amounts per enrollee.

Each plan's expected per enrollee transfer amount is equal to:

(1 - plan's expected relative risk) (reference premium)

$$\text{Plan A: } (1 - 0.85000) (200.00) = 30.00$$

$$\text{Plan B: } (1 - 1.03333) (200.00) = - 6.67$$

$$\text{Plan C: } (1 - 1.16667) (200.00) = - 33.33^*$$

* rounded

Expected Transfer Amount

Plan A - \$30.00

Plan B - (\$6.67)

Plan C - (\$33.33)

E. Developing standardized community rate.

Each plan's/carrier's standardized community rate equals its unadjusted community rate plus the expected transfer amount, further adjusted for other contingencies. In this example, we do not include an adjustment for other contingencies.

$$\text{Plan A: } \$190 + 30.00 = \$220.00$$

$$\text{Plan B: } \$210 - 6.67 = \$203.33$$

$$\text{Plan C: } \$240 - 33.33 = \$206.67$$

Standardized Community Rate

Plan A - \$220.00

Plan B - \$203.33

Plan C - \$206.67

These are the rates that each plan/carrier charges per person enrolled.

Step 4 RA Administrator publishes rates.

Step 5 Enrollment.

Step 6 Health plans/carriers report actual enrollment data to the RA Administrator.

The plans/carriers report the following enrollment:

Actual 1994 Enrollment (number of enrollees)				
Plan	Category 1	Category 2	Category 3	Total
A	1000	3000	1000	5000
B	1500	4500	2500	8500
C	1500	2500	2500	6500
Whole Community	4000	10,000	6000	20,000

Step 7 RA Administrator calculates transfer amounts and administers revenue transfers.

A. Actual relative risk.

RA Administrator calculates each plan's/carrier's actual relative risk:

The actual relative risk is a weighted average of the category relative risk factors, weighted by the actual proportion of enrollees in each category.

$$\text{Plan A: } (1000 (0.6) + 3000 (0.8) + 1000 (1.6)) / 5000 = 0.92000$$

$$\text{Plan B: } (1500 (0.6) + 4500 (0.8) + 2500 (1.6)) / 8500 = 1.00000$$

$$\text{Plan C: } (1500 (0.6) + 2500 (0.8) + 2500 (1.6)) / 6500 = 1.06154$$

* rounded

Actual Relative Risk

Plan A - 0.92000

Plan B - 1.00000

Plan C - 1.06154

B. Transfer amounts.

The transfer amount for each plan/carrier is calculated according to the following formula:

$$\text{Transfer Amount} = (1 - \text{plan actual relative risk}) (\text{reference premium}) (\# \text{ enrollees})$$

$$\text{Plan A: } (1 - 0.92000) (\$200) (5000) = \$80,000^*$$

$$\text{Plan B: } (1 - 1.00000) (\$200) (8500) = 0$$

$$\text{Plan C: } (1 - 1.06154) (\$200) (6500) = (\$80,002)^*$$

* transfers do not add to \$0 because of rounding.

C. Revenue transfers.

The RA Administrator instructs Plan A to pay into the pool \$80,000. The RA Administrator then pays out \$80,002 to Plan C. Plan B, in our example, transfers neither in nor out.

Risk Adjusters and the Health Security Act

by P. Anthony Hammond, ASA, MAAA

SUMMARY

The Act provides for development of a fully prospective, zero sum, risk adjustment mechanism based on factors related to demographics, health status, area of residence, socioeconomic status and, possibly, welfare status. Although the methodology for the mechanism is to be promulgated by the National Health Board, it is supposed to address regional differences in health care cost and utilization. Shortfalls in transfer payments as a result of actual enrollment results being different from expected can be made up by adjustments to next year's transfers. Regional alliances are required to apply the system to health plan payments.

The Act requires the National Health Board to establish a mandatory reinsurance mechanism that applies to all regional alliance health plans if it determines that an adequate system for prospective risk adjustment cannot be developed by April 1, 1995. The mechanism would reinsure plans for specified classes of high-cost enrollees, treatments or diagnoses. The reinsurance premiums may be either prospective or retrospective. The reinsurance mechanism may be reduced or discontinued when a more adequate prospective risk adjustment mechanism is developed. States would implement the system.

ANALYSIS

The description of this mechanism is reasonably compatible with the HIAA Risk Adjustment Workgroup recommendations for an interim risk adjustment mechanism.

The Act allows for continual development of an adequate risk adjustment mechanism. We would want to be involved with the advisory committee for developing the RAM. Defining what is an "adequate" risk adjuster will be important.

The Act requires development of a zero sum mechanism and allows for shortfalls of transfer payments when enrollment estimates are different from actual, but there can be other reasons for shortfalls. The transfers based on the relative risk factors and reinsurance payments are unlikely to be perfect because these are estimates subject to statistical variation and prediction error. Shortfalls could be generated from using these estimated values as easily as from enrollment estimates. Thus, the Act should not limit the carryover for shortfalls to just differences in enrollment projections.

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The question of whether any risk adjuster working in an individual choice environment is adequate to compensate for individual adverse selection has still not yet been answered. This is all the more important when all plans are forced to participate in the regional alliance.

One concern would be whether the reinsurance premiums are prospective or retrospective. They should be prospective. New York handles this by charging a \$5 per person premium prospectively to establish the reinsurance fund which then makes payments to plans based on occurrences of certain high cost conditions. A similar approach where premiums are prospective and payments are retrospective would be reasonable.

Making the RAM dependent on services to disadvantaged populations would be a mistake. Risk adjustment factors that reflected these services explicitly would probably be very subjective. Besides, the health services needed when one has appendicitis should be unrelated to how much access one has to the system or what barriers might exist to obtaining health care.

Requiring risk adjustment factors to specifically consider certain illnesses--such as mental illness--implies subjective prejudices regarding what conditions most reasonably reflect the health status of individuals. Instead, factors should be based on fair, objective criteria, applied consistently, which identifies those conditions that would be most predictive of health status.

Risk adjustments should not be based on factors which do not directly relate to health status, e.g., barriers to access.

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References to Risk Adjustment in Proposed Health Security Act

Title I: Health Care Security

- \$1203: State responsibilities relating to health plans.
- \$1351: Payment to regional alliance health plans.
- \$1541: Development of a risk adjustment and reinsurance methodology.
- \$1542: Incentives to enroll disadvantaged groups.
- \$1543: Advisory committee.
- \$1544: Research and demonstrations.
- \$1545: Technical assistance to States and alliances.

Title V: Quality and Consumer Protection

- \$5003: National measures of quality performance.
- \$5120: Health information system privacy standard.

Title I: Health Care Security

Subtitle C: State Responsibilities

\$1203: STATE RESPONSIBILITIES RELATING TO HEALTH PLANS.

- (g) Implementation of Mandatory Reinsurance System. If the risk adjustment and reinsurance methodology developed under section 1541 includes a mandatory reinsurance system, each participating State shall establish a reinsurance program consistent with such methodology and any additional standards established by the Board.

Subtitle D: Health Alliances

\$1351: PAYMENT TO REGIONAL ALLIANCE HEALTH PLANS.

- (c) Application of Risk Adjustment and Reinsurance Methodology. Each regional alliance shall use the risk adjustment methodology developed under section 1541 in making payments to regional alliance health plans under this section, except as provided in section 1542.

Subtitle F: Federal Responsibilities

PART 1: NATIONAL HEALTH BOARD

**Subpart E: Risk Adjustment and Reinsurance
Methodology for Payment of Plans**

**\$1541: DEVELOPMENT OF A RISK ADJUSTMENT AND REINSURANCE
METHODOLOGY.**

(a) Development

- (1) Initial development. Not later than April 1, 1995, the Board shall develop a risk adjustment and reinsurance methodology in accordance with this subpart.

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- (2) Improvements. The Board shall make such improvements in such methodology as may be appropriate to achieve the purposes described in subsection (b)(1).

(b) Methodology

- (1) Purposes. Such methodology shall provide for the adjustment of payments to regional alliance health plans for the purposes of:
- (A) assuring that payments to such plans reflect the expected relative utilization and expenditures for such services by each plan's enrollees compared to the average utilization and expenditures for regional alliance eligible individuals, and
 - (B) protecting health plans that enroll a disproportionate share of regional alliance eligible individuals with respect to whom expected utilization of health care services (included in the comprehensive benefit package) and expected health care expenditures for such services are greater than the average level of such utilization and expenditures for regional alliance eligible individuals.
- (2) Factors to be considered. In developing such methodology, the Board shall take into account the following factors:
- (A) Demographic characteristics
 - (B) Health status
 - (C) Geographic area of residence
 - (D) Socio-economic status
 - (E) Subject to paragraph (5):
 - (i) the proportion of enrollees who are SSI recipients and
 - (ii) the proportion of enrollees who are AFDC recipients.
 - (F) Any other factors determined by the Board to be material to the purposes described in paragraph (1).
- (3) Zero sum. The methodology shall assure that the total payments to health plans by the regional alliance after application of the methodology are the same as the amount of payments that would have been made without application of the methodology.
- (4) Prospective adjustment of payments. The methodology, to the extent possible and except in the case of a mandatory reinsurance system described in subsection (b), shall be applied in manner that provides for the prospective adjustment of payments to health plans.
- (5) Treatment of SSI/AFDC adjustment. The Board is not required to apply the factor described in clause (i) or (ii) of paragraph (2)(E) if the Board determines that the application of the other risk adjustment factors described in paragraph (2) is sufficient to adjust premiums to take into account the enrollment in plans of AFDC recipients and SSI recipients.
- (6) Special consideration for mental illness. In developing the methodology under this section, the Board shall give consideration to the unique problems

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of adjusting payments to health plans with respect to individuals with mental illness.

- (7) Special consideration for veterans, military, and indian health plans. In developing the methodology under this section, the Board shall give consideration to the special enrollment and funding provisions relating to plans described in section 1004(b).
- (8) Adjustment to account for use of estimates. Subject to section 1346(b)(3) (relating to establishment of regional alliance reserve funds), if the total payments made by a regional alliance to all regional alliance health plans in a year under section 1324(c) exceeds, or is less than, the total of such payments estimated by the alliance in the application of the methodology under this subsection, because of a difference between:
 - (A) the alliance's estimate of the distribution of enrolled families in different risk categories (assumed in the application of risk factors under this subsection in making payments to regional alliance health plans), and
 - (B) the actual distribution of such enrolled families in such categories,
 the methodology under this subsection shall provide for an adjustment in the application of such methodology in the second succeeding year in a manner that would reduce, or increase, respectively, by the amount of such excess (or deficit) the total of such payments made by the alliance to all such plans.

(c) Mandatory Reinsurance

- (1) In general. The methodology developed under this section may include a system of mandatory reinsurance, but may not include a system of voluntary reinsurance.
- (2) Requirement in certain cases. If the Board determines that an adequate system of prospective adjustment of payments to health plans to account for the health status of individuals enrolled by regional alliance health plans cannot be developed (and ready for implementation) by the date specified in subsection (a)(1), the Board shall include a mandatory reinsurance system as a component of the methodology. The Board may thereafter reduce or eliminate such a system at such time as the Board determines that an adequate prospective payment adjustment for health status has been developed and is ready for implementation.
- (3) Reinsurance system. The Board, in developing the methodology for a mandatory reinsurance system under this subsection, shall:
 - (A) provide for health plans to make payments to state-established reinsurance programs for the purpose of reinsuring part or all of the health care expenses for items and services included in the comprehensive benefit package for specified classes of high-cost enrollees or specified high-cost treatments or diagnoses; and

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- (B) specify the manner of creation, structure, and operation of the system in each State, including
 - (i) the manner (which may be prospective or retrospective) in which health plans make payments to the system, and
 - (ii) the type and level of reinsurance coverage provided by the system.
- (c) Confidentiality of Information. The methodology shall be developed in a manner consistent with privacy standards promulgated under section 5102(a). In developing such standards, the Board shall take into account any potential need of alliances for certain individually identifiable health information in order to carry out risk-adjustment and reinsurance activities under this Act, but only to the minimum extent necessary to carry out such activities and with protections provided to minimize the identification of the individuals to whom the information relates.

\$1542: INCENTIVES TO ENROLL DISADVANTAGED GROUPS.

The Board shall establish standards under which States may provide (under section 1203(e)(3)) for an adjustment in the risk-adjustment methodology developed under section 1541 in order to provide a financial incentive for regional alliance health plans to enroll individuals who are members of disadvantaged groups.

\$1543: ADVISORY COMMITTEE

- (a) In General. The Board shall establish an advisory committee to provide technical advice and recommendations regarding the development and modification of the risk adjustment and reinsurance methodology developed under this part.
- (b) Composition. Such advisory committee shall consist of 15 individuals and shall include individuals who are representative of health plans, regional alliances, consumers, experts, employers, and health providers.

\$1544: RESEARCH AND DEMONSTRATIONS.

The Secretary shall conduct and support research and demonstration projects to develop and improve, on a continuing basis, the risk adjustment and reinsurance methodology under this subpart.

\$1545: TECHNICAL ASSISTANCE TO STATES AND ALLIANCES.

The Board shall provide technical assistance to States and regional alliances in implementing the methodology developed under this subpart.

Title V: Quality and Consumer Protection**Subtitle B: Information Systems, Privacy, and Administrative Simplification****PART 2: PRIVACY OF INFORMATION****\$5120. HEALTH INFORMATION SYSTEM PRIVACY STANDARDS.**

- (c) Principles. The standards established under subsection (a) shall incorporate the following principles:
 - (3) Risk adjustment. No individually identifiable health information may be provided by a health plan to a regional alliance or a corporate alliance for the purpose of setting premiums based on risk adjustment factors.

Mr. WAXMAN. Mr. Jones, you argue that we don't know how to minimize risk selection or how to adjust premiums for it sufficiently to prevent it from destroying competition based on cost containment and quality. You stated that as a rule of thumb only 20 percent of the potential risk selection and multiple choice arrangements can be corrected by premium adjustments. That, of course, leaves 80 percent of the effects of risk selection unaccounted for. They could be windfall profits or wipe-out losses.

Ms. Rosenblatt, you seem to agree with Mr. Jones that our current ability to adjust for risk selection is inadequate. However, you argue that by April 1, 1995, a workable solution can be found.

And, Mr. Neuschler, you testified that it is possible to develop a risk adjustment mechanism that will work adequately if insurers are enrolling employment-based groups, but you do not think it is possible to develop such a mechanism in purchasing, in a purchasing environment in which individuals choose their own health plans.

Of course one of the great strengths of the Clinton bill is precisely that individuals, not employers, are given freedom of choice of plans. So what are we to make of this? Can we solve the problem of adjusting plan premiums for enrollee risk in a market where individuals are allowed to choose their health plans, or, is Mr. Jones correct when he argues that health plans will always be able to game the system? I would like to hear your responses to that.

Mr. BOWEN. Being the advocate I guess here, or the primary advocate of risk adjustment as a solution, first I think it is probably one of the few games in town in terms of—

Mr. WAXMAN. That is what we are worried about.

Mr. BOWEN. Yes. What have we got if we don't use it? Where are we with choice? We are in trouble with choice if we can't adjust for the risk. If we can't remove the effect of who else chose the plan from the price that people see, we will never have competition.

Some people said that the health alliances in this reform will be the downfall of fee-for-service plans. From my perspective, it is the only way they will survive is through a scheme where there can be risk adjustment.

I am much more optimistic, I think, than Stan in terms of finding ways to solve these marketing games that are played by some of our competitors. We have seen them happen in the market. I will tell you that I—Mr. Jones must have been advising our competitors about what to do. But I think that the combination—

Mr. WAXMAN. What is the median age of your doctors?

Mr. BOWEN. I don't know.

I think that it takes a combination of regulatory effort and the risk adjusters to make this work. They can't work either one all on their own. It is really those things have to work in tandem. And the health alliances have to have sufficient clout to prevent the kind of behavior Mr. Jones is talking about. Risk adjusters can't possibly deal with that.

On the other hand, many of us in the business have been dealing with risk for a long time. We have been measuring it. We deal with it every day in figuring out what our rates are. This isn't rocket science. We can figure out how to do this. And all the pieces are not in place today but they can be in place, I am quite confident.

Mr. WAXMAN. Ms. Rosenblatt?

Ms. ROSENBLATT. We too believe—the actuaries on our work group and the non-actuaries on our work group do believe that risk adjustment is absolutely necessary and, as you quoted, that a workable solution can be found.

I think we are also visualizing an approach that becomes—you don't get to the 100 percent solution on day one, but you put in a short-term solution and then as experience emerges on that you learn what the pitfalls of that are, but that is probably good enough to get it started, and that is why we are recommending a system like New York.

Our work group is actually studying the experience that is occurring in New York right now. We have some people from the Division of Insurance in New York added to the work group, and we will be examining that, and we expect to have another report completed by March that may be able to give some preliminary indications on that.

We also think that if there are people in the industry that have been able to do a superb job at cherry-picking, then that the same techniques that enabled people to be able to do that cherry-picking can be applied to create a good risk adjustment mechanism.

So we think it is just a matter of getting enough people working on it, and a lot of people are working on it right now. There is a lot of research going on and what we will probably end up with is a short-term solution followed by something that gets more and more sophisticated as time goes on.

Mr. WAXMAN. Mr. Neuschler?

Mr. NEUSCHLER. We too agree that there absolutely has to be a risk adjuster to make this system work. We think we can do one on employment-based groups and we are willing to be proved wrong. For the individual market, we are not convinced that one can be done for that at the moment.

I think it is interesting to point out that the kinds of mechanisms that plans are using to try to select risk that Mr. Jones talked about are ones that are primarily used in an individual choice environment, and I think that sort of points out the additional difficulty of dealing with that environment as opposed to the current employer choice environment.

Now, choice is a tricky issue here. You have got choice of health plan. You have got choice of doctor. You have got long run availability of alternatives in the marketplace. We at the Health Insurance Association at this point are focusing on two—what we think are the two critical pieces. One is continued ability of consumers to choose their doctors, and the second is the long run viability of a range of alternatives in the marketplace so that we don't end up with a system where we have really reduced competition down to a handful of plans in each regional alliance area and they are behaving like oligopsonists and we don't really have innovation and creativity and the competitive urge to look for better ways to do things that you have when you have a truly competitive market. That is really what we are looking for over the long run.

Mr. JONES. Mr. Chairman, can I tweak my colleagues?

First of all, I think that you are hearing a more fundamental opposition to market management and individual choice from HIAA

than may appear. The experience I have had is in employer markets. It is in employer markets, big employers where individual employees have a choice of multiple plans.

The only way that you can get around risk selection in that market other than to develop the kind of adjusters we are arguing about is to eliminate the multiple choice, and a lot of employers are opting for that these days out of despair at the risk selection and the problems they are having managing the multiple choice plans, going back to one insurer.

I am not sure but the HIAA may be saying we should go back to one insurer which the employer picks which really is at the heart of this market reform approach. To abandon that is a big thing.

But beyond that I think the issue—the disagreement you are hearing has to do with how much how soon, not whether you can ever do it, although I think there is some chance we will never be able to do it. I think this may turn out to be an unsolvable risk assessment problem, and there are such problems.

The question is can we have adequate enough risk adjuster by the time we start this program that we dampen or take away the incentive of insurers to use risk selection as a primary tool for competition to keep their premiums down. I think that is genuinely a long shot, and I am delighted that the Academy and Bruce and his colleagues are researching all this—I mean doing work on this. I mean important stuff.

But I don't think we are going to make it unless there is something comparable to a special Manhattan Project kind of effort which one moves things that are in the private arena into the public. The things I have described are all private research, millions of dollars worth, that frankly we were taking—selecting the pants off of employers and they didn't even know it was happening because they weren't doing any of the research.

There is very little public research in this area. A lot of it is privately held in big consulting firms. We need it in the public sector. We need to make a concerted effort that is backed by government. We did something on claims forms. This is much more important to the system's working than claims form and efficiency and processing claims forms is. And that is what I would like to pitch for.

Shy of that, if we don't make it, I think a more urgent step is required, which is to give alliances capacity to limit the number of plans who compete. It is a drastic thing to do, but I can tell you if I were managing an alliance and there were a hundred plans there out there, I don't have a prayer of catching them doing the subtle marketing things I have described. If there are 10, I might. But put a hundred out there and I just don't have the capacity to keep up with them.

That is also contrary to the competitive intent of these proposals, but I think the problem is that severe, and I don't think we will make it given the best efforts that we can make unless we mount something like I have described.

Mr. WAXMAN. Earlier in her testimony Dr. Feder indicated that alliance payments to plans under the President's bill will be adjusted for the age of its enrollees, the proportion of cash assistance enrollees and for higher health costs in certain geographic areas.

Beyond this the administration seems to be relying on mandatory participation in the reinsurance program to help plans that end up with a disproportionate number of high cost or chronically ill patients.

My question to all of you or whichever of you wishes to respond concerns the potential for plans to continue their avoidance of high risk people. From a plan's perspective, do you think the President's bill includes sufficient protections, protections against the risk of adverse selection so that they will no longer feel the need to engage in marketing strategies designed to attract only the healthiest people?

Ms. Rosenblatt?

Ms. ROSENBLATT. I think that one very dangerous part of the President's plan as it stands right now is the premium cap, which ties into a lot of other things and would tend to make carriers want to keep their premiums as low as possible. It would generate a tremendous amount of fear of what happens if I get a lot of high risk, if the risk adjustment mechanism doesn't work properly, and I have no way of recovering that future years' premium increases.

Mr. BOWEN. I think that the standard is really will plans feel that they are being adequately compensated for the risks that they get. And it might be to a plan's advantage, and I will quickly give you a scenario, to have high risk people in the plan if, in fact, they are compensated adequately for them.

For example, if I am running a health plan and I have only healthy people in it, I can't charge very much and there isn't much opportunity to save money. If they don't use any services, it is hard to be efficient in the delivery of no services.

On the other hand, if I have a plan for very sick people and I am very good at managing their care, and I am compensated fairly for it, I can make money. And I suspect that the health plans will begin to discover this. And if we can design the mechanisms so that they are fairly compensated for the ones they get, that is the best world. Second best would be to spread the risk evenly and have no selection bias.

But selection bias isn't bad if it is compensated for by the risk adjustment scheme.

Mr. WAXMAN. Mr. Jones?

Mr. JONES. We had a comment on this reinsurance idea. It seems to me there is great good that can come of that, and Bruce just referred to it. If you are a chronic arthritic in several areas of our country where there are HMO's who have very good programs for chronic arthritics, you will probably not find out about those programs unless your neighbor tells you. They won't be advertised during open season. They can't afford to advertise them.

If you had a system that took the payment for those specific conditions out of the mix, then those HMO's could advertise and get the best organized care around to those people because they could enroll them and get paid.

However, I don't believe that reinsurance programs substantially reduces the risk selection issue. It may seem to, but let me give you an example. If 25 or 30 percent of the people use no care in a year, and a number of people, 5 percent, 80 percent—is that the split we

use? —are at this end of the tail of the curve, you can start carving people out of that high end.

And let's say you take out so many diagnoses and so many different conditions that you actually get it to where people who use over \$25,000 a year are pretty much in the reinsurance program. So, gee, now you have reduced the range from zero for 25 percent to \$25,000 for a handful. That is a lot of room for risk selection.

Risk selection tactics are used aggressively by insurers in Medicare supplemental coverage where the cap is very low, their liability. It is because Medicare picks up most of the cost, and yet they compete for the healthier elderly people and it makes a huge difference in your competitiveness of premium.

So, I think the reinsurance pool is a good idea, but not as a way of substantially reducing the incentive to risk selection.

Mr. BOWEN. Could I add one thing on the reinsurance pool?

Mr. WAXMAN. Yes.

Mr. BOWEN. One of the things that I think when Stan's talking about reinsurance pool and when I am talking about it and Alice is I am not sure we are talking about the same thing as the administration is talking about with the reinsurance pool. We are talking about a reinsurance pool where there are some defined medical conditions, that there is prospectively determined what those are and what the payment will be. The health plan has one of those.

Often reinsurance pool means any claim over X thousand dollars the reinsurance pool pay a certain percentage of it. We don't think those work, or I don't think those work. I won't speak for the other people. But just to clarify that issue.

Mr. WAXMAN. Mr. Neuschler, you want to add something?

Mr. NEUSCHLER. Just very briefly. I think Mr. Jones has given an excellent description of why we are skeptical about ability to have a workable risk adjustment mechanism when choice is on an individual basis. But when you have employer groups coming together, you can't shave off people very readily. You get a group. It may be a small group, but you get a group, and you get the range of risk in that group. And we think that's a much more tractable system, particularly for the short term, something we can deal with. We know how to work with it and we think it is a way to move forward.

Mr. WAXMAN. Thank you.

Mr. Greenwood?

Mr. GREENWOOD. Thank you, Mr. Chairman.

I would like to return to the issue that Ms. Rosenblatt touched upon a moment ago of the relationship of premium caps and risk adjustment. We have heard throughout the day that the risk adjustment process is work in progress, and we know that HCFA has taken 10 years to try to develop one. We are now being asked to roll the dice for the entire country's health care and gamble on the fact that we are going to be able to do this somehow very quickly, and it is going to work.

But what happens if the administration is wrong and we don't have an effective risk adjustment scheme and we bump into premium caps? We have plans out there which have no control over their premiums and who have no control over devising the risk adjustment. What is that likely to do for solvency?

Ms. ROSENBLATT. I agree. As I said earlier, I think that is a great concern. And there is another aspect that I should have mentioned in addition to that, which is the 20 percent. The way the plan is structured right now, if a given plan falls outside—20 percent greater than the average, that plan cannot be offered.

So that if a given plan does experience adverse selection not only are there solvency concerns if the risk adjustment mechanism doesn't appropriately pick that up, but that plan may not be offered anymore, so again has no way of recovering the losses it has sustained.

So, I think Dr. Bowen mentioned earlier that the risk adjustment mechanism needs to be put in the context of the total program. So, standard plan design, guaranteed issue, a lot of those things will reduce the amount of adverse selection. The fact that there is choice of individual plans and many other factors that have been mentioned today will add to it. And we have got to work with the whole system and deal with the pieces, I think, that have some problems.

And two of the ones that I personally think would create problems while we are in an experimental mode, and I think it is OK to be in an experimental mode, but I think we need to be real careful about parts of the plan like the 20 percent factor and like the premium cap.

Mr. GREENWOOD. Any of the other panelists care to comment?

Mr. JONES. I think that a short answer to your question is if risk selection continues the efficient plan won't be rewarded for its efficiency. And, in fact, it may be hurt if it happens to be selected against and the inefficient plan could do all right. That is kind of really what the real world—that undermines the basic idea of a competitive market aimed at containing cost. This is a real spoiler issue.

Ms. ROSENBLATT. I would just like to add that that happens so much in today's environment and that is why we feel very strongly that risk adjustment is needed even if we need to do it experimental. But in certain States today where there are some carriers that by State regulation are required to community rate, are required to do guaranteed issue, other carriers have been doing medical underwriting and various other forms of cherry-picking, you end up with the carrier that is required to do guaranteed issue and community rating might be the most efficient carrier in that State and yet have the highest premium. So, in order to avoid that, it becomes very necessary to deal with risk adjustment.

Mr. GREENWOOD. Some of you may have been here earlier when I asked Dr. Feder a question about the prohibition in the bill on presenting advertising materials to less than the entire area of a health plan's coverage. I came in a little late, and I apologize for that, but there has been some talk, obviously, about clever ways to do their selecting, and it would seem to me that deciding which television station or radio station or magazine to advertise in, whether your television commercial has people with young families with new babies coming along or whether it is older Americans strolling in the park, is going to make a difference in who you attract to your plan.

Do you think that this part of the bill is really as problematical as I think it may be in terms of putting a real chill on how companies advertise?

Mr. JONES. I don't think that part of the bill will work. Let me give you just a brief example of a plan for which I worked, and I have got to tell you that it was in such bad shape in terms of adverse selection I felt very righteous helping them try to hold onto their low users and get better selection.

But they found they were losing in several successive open seasons lots of people to Kaiser. Bruce alluded to it a while ago. They did a very careful research job using a nationally known firm to find out who was leaving, and they found that based on their claims costs they were low users leaving. And the research firm told them what the low users were looking for when they went to Kaiser.

They went back and asked a more sophisticated marketing question; namely, is there any residual doubt or anxiety in those low users about Kaiser that we could play on? The answer was yes. This was not in California, incidentally. The anxiety was I don't really know what this HMO thing is. So, that following open season this insurer launched an add campaign around the simple notion, "Stay with X, you know who we are." Advertised everywhere in the area.

Mr. GREENWOOD. That is what my opponent did in the last campaign rather well.

Mr. JONES. You have got it. You have got the model.

They used every media outlet. They didn't do that, but in fact they almost completely pinched off the outflow of their low users to Kaiser. That is the level of sophistication we are talking about here. It is the same sophistication, in fact, that media people and market people in the politics area use.

Mr. GREENWOOD. Any other comments? Yes, sir?

Mr. NEUSCHLER. I would just like to say that this is more of a problem when you have got an individual choice or you are using mass media rather than more traditional selling to employers who are really looking at the bottomline and looking at your track record both on cost and customer service and that sort of thing.

I also don't think that it would be possible to write a regulatory kind of provision that would deal with every eventuality. That is why in order to have a fairer marketplace we do have to have a risk adjustment mechanism that removes the incentive for plans to select risk, that make sure that if they get a lot of healthy risks that they have to pay into a pool and therefore it removes the financial incentive to do it, because you are not going to be able to regulate it entirely. You have to, obviously, have basic rules there, but you can't oversee everybody.

Mr. GREENWOOD. Is your comment that the issue of targeted marketing is less of a problem because we are going to have more group purchasing than individual purchasing? Are you arguing that we should worry about that section or to take it out?

Mr. NEUSCHLER. I think we would be supportive of general rules at the Federal level that talk about fair marketing practices, so I guess I would leave it in. And certainly, even with employer-based

stuff, you are going to have to have oversight of the marketing practices and make sure there is nothing really egregious going on.

But the risk adjustment is critical, because if you can't remove the financial incentive for plans to try to select risk, then you are always going to be chasing after them, and you will never, you know, completely catch up with them.

Mr. GREENWOOD. I would like to, if I still have some time, shift gears a little bit. The President's health plan excludes all but employers with more than 5,000 employees from participating in corporate alliances. The question is what do you think is the appropriate number of employees to allow a company to form a corporate alliance? Would any of you care to comment on that?

Mr. NEUSCHLER. I will take a stab at it. We think that the critical issue is not so much the size cut-off, but making the alliances voluntary in the first place so that no employer is forced to use the alliance if they don't want to.

And, as I said, we think we can develop a risk adjustment mechanism if things are going on an employer basis that we can guarantee that the alliance as a whole will not be selected against by insurers who are selling to employers outside or by the employers themselves making decisions based on their assessment of the risk of their own people. So we focus primarily on the voluntary aspect unless on the cut-off number.

Mr. GREENWOOD. I tend to agree with you, but suppose I lose that debate and my fallback position is changing the 5,000, moving that number downward.

Mr. JONES. If you ask the question at what size can employers manage the competition of competing health plans so as to achieve savings, I think 5,000 is a conservative side. I have never found an employer that we have worked with smaller than that who is really saving money through managing multiple choice.

I would also like to suggest that if you made this voluntary and you allowed marketing research like the kind I am describing to be used by insurers in determining which employers they would sell to and whom they would leave in a position of moving into the alliance. I think you could devastate the alliance with risk selection.

Mr. BOWEN. I completely agree with that statement about making it voluntary. It would raise the level of risk selection bias problems to definitely an unmanageable level.

Mr. GREENWOOD. Do you want to defend your self against those charges?

Mr. NEUSCHLER. Well, I don't—I find it hard to understand how you can have a risk adjuster that is adequate to deal with an individual choice environment, where individual people who know what their own situation is are deciding which plan to choose, and have a risk adjuster that will work in that environment and not have that adjuster be adequate to deal with selection effects where insurers might be marketing and taking employment groups outside the alliance.

We strongly feel that whatever risk adjustment mechanism is put in place has to apply to the entire market, the regional area and whatever the market size is that is eligible to use the HIPC, the risk adjustment mechanism has to apply in that entire market

regardless of whether the health plan markets itself through the alliance or directly to employers.

So we definitely agree with the pooling on that level. And, if you do that I don't understand how it is a harder problem than solving the individual choice within the alliance.

Mr. BOWEN. It is a harder problem because now you have not only risk selection between health plans, you have risk selection between competing alliances and you have risk selection among the people who are in the alliance and not in the alliance.

And people who are not in the alliance, as I understand it, would not have to have the standardized benefit package. If you didn't have the standardized benefit package, then you have to compensate for the difference in benefits which just raises another level of complexity to the risk adjuster mechanisms.

So you have to not—you are adding levels, you are adjusting this and then you are adjusting across alliances and then you are adjusting across benefit patterns. It just adds complexity to the problem and reduces, I think, the chances that you could do it right.

Mr. NEUSCHLER. I apologize for not laying out the full range of our proposal, but we do propose standard benefits across the entire market, and the only difference between inside the alliance and outside would be the method of arranging coverage. Everything else would be the same.

Mr. WAXMAN. If the gentleman would yield?

Could you respond to that point? If it is a standardized benefit that must be offered, you have then full competition, different alliances, and competition between alliances and plans, but a risk adjustment within a specified geographic area effecting the whole population no matter what alliance or plan they might have participated in?

Mr. BOWEN. OK. Then what you have added is—I take back my part about the complexity added by benefit packages. You still have the complexity added by having to do—if you have an alliance that is exclusive and covers a geographic area for a defined group of people, whether it is 200 an employer or 5,000, but it is defined, then you have—your problem is to estimate the relative cost of people who join Health Plan A versus the relative cost of people who join Health Plan B. That is the only problem that you give the risk adjustment and assessment mechanism.

If you have multiple health alliances, you have that problem plus you have to estimate the differences between those people who join Alliance A versus the people who join Alliance B. And, if you allow individual employers to form their own alliances, you have to look at the risk of the people who are in this employer group versus that employer group.

If those employer groups are relatively small or those alliances are fairly small, these risk adjustment mechanisms break down, because they need the laws of large numbers in order to work well. The error for predicting the cost of a small group of people, and small we are talking a few hundred rather than thousands, is much, much higher. So there are, in effect, two kind of problems that are generated by this.

Mr. GREENWOOD. Thank you, Mr. Chairman. One more question.

The Clinton plan assumes that you must establish mandatory alliances run by the State in order to facilitate health plans that community rate and guarantee issue. However, isn't it possible to distribute risks appropriately through voluntary alliances as long as the single risk adjuster is collecting information from each health plan? Isn't it true that if a risk adjustment system works, then it doesn't matter if the alliance is mandatory or voluntary or if there is no alliance at all?

I am reading that question to you because that is related to what we have just been discussing.

Mr. NEUSCHLER. That is basically exactly our point. It doesn't matter how many alliances you have or how many people are selling outside. You take every health plan that is serving that area and they have to participate in the risk adjustment mechanism, and they are adjusted based on the enrollees that they have regardless of how they get them.

And, in fact, I think from our perspective the ability of smaller plans to continue to participate in the system may be critical to the ongoing evolution of better ways of doing things. If we end up with just three or four big plans in a regional alliance area, yes, risk adjustment is easier to do because the law of large numbers takes over, and maybe you don't even need to do it at all.

But what have you done to the marketplace competition? Are you really going to have plans really trying to find a better way to serve people at a lower price or are they just going to sort of carve up the market and say the premium caps are binding anyway and we are just going to satisfy us here and, you know, sit where we are.

Mr. JONES. I would ask a question of Ed. Are you suggesting that employers like alliances would have to offer all certified health plans in the area or could they just pick a couple of plans of their choice to offer their employees, or maybe only one plan?

Mr. NEUSCHLER. We are not suggesting that employers would have to offer all the plans in the area. We are suggesting that every employer, in order to maintain individual access to physicians we are talking about having employers offer at least one plan that has what we are calling meaningful out of network choice, yet to be defined.

But the issue—the risk adjustment mechanism would work across all health plans. So that if an employer had a self-insured, self-funded plan, they would have to participate in the mechanism. If they bought coverage through two competing plans, those plans as plans would have to participate in the mechanism.

Mr. JONES. So, they may have to contribute money to the plans that are in the alliance—

Mr. NEUSCHLER. Right. Exactly.

Mr. JONES [continuing]. Because they have better risks.

Mr. NEUSCHLER. Exactly.

Mr. JONES. You really need a very precise and good risk adjuster to do that. I mean really precise.

Mr. NEUSCHLER. Well, as I said, I think the level of precision depends on the degree of individual choice involved, and if you are moving employer groups around the degree of variation before you

even start, before you even start adjusting, just is not as big. So, you don't have to adjust as much.

Mr. BOWEN. You offer health plans another opportunity, however, to select risk by selecting which employers they make themselves available to.

Mr. NEUSCHLER. Well, we are talking guaranteed issue here, which is not to say that there aren't marketing things that can be done. But if someone came to you, you as a health plan, you would have to issue a policy.

Mr. JONES. But the employer could decline that plan. The employer could say, "No, I am just taking that plan"——

Mr. NEUSCHLER. No, the—yes, it is the employer choosing what he wants to do, whether he wants to have his people participate in the alliance or deal directly with a plan.

Mr. JONES. I would love to have my market researchers go to work with that one.

Mr. WAXMAN. Well, I am reluctant to call a conclusion to this discussion because I was hoping you could find some middle ground. But apparently not for today.

I think this has been an excellent panel and you have given us a lot to think about. And, as you think about it, I hope you will share further thoughts with us.

Thank you.

On our final panel, we will hear from representatives from the types of entities that can operate as corporate alliances under the President's plan.

Dr. Bruce Karrh is Vice President for Integrated Health Care of the DuPont Company in Wilmington, Del.

Judith Mazo is Senior Vice President of the Segal Company and is testifying on behalf of the National Coordinating Committee for Multi-Employer Plans.

And Anthony C. Williams is the Director of the National Rural Electric Cooperative Association.

I welcome you today to our hearing. Without objection, your written statements will be included in the record in full. We would like to ask you to limit the oral presentation to no more than 5 minutes.

Mr. Karrh, why don't we start with you?

STATEMENTS OF BRUCE KARRH, VICE PRESIDENT, DuPONT CO., ON BEHALF OF CORPORATE HEALTH CARE COALITION; JUDY MAZO, ON BEHALF OF NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS; AND ANTHONY C. WILLIAMS, DIRECTOR, RETIREMENT, SAFETY, AND INSURANCE DEPARTMENT, NATIONAL RURAL ELECTRIC COOPERATIVE ASSOCIATION

Mr. KARRH. Thank you, Mr. Chairman, members of the subcommittee.

My name is Bruce Karrh. I am a physician and Vice President of Integrated Health Care for the DuPont Company in Wilmington, Del. I am here today on behalf of the Corporate Health Care Coalition, a group of large self-insured multistate companies recently formed to support the enactment of health care reform legislation.

At present the coalition has 19 member companies. In combination, we provide health benefits for over 2.8 million people in all 50 States at a cost of \$6.8 billion per year. Each of us could qualify as a corporate alliance under the President's health care reform proposal.

Our coalition is unique in one way. The primary health care concerns of all of our members are solely as purchasers of health care for our employees. Many of our members have been in the forefront of efforts to ensure high quality and cost effective benefits for employees.

We have extensive experience in designing and operating health benefits, and have been a major force in ongoing efforts to restructure the health care delivery system.

Let me begin, Mr. Chairman, by saying that our coalition is committed to the enactment of a comprehensive health care reform plan consistent with our principles by the end of next year. We are pleased that the President has taken the leadership to draft and introduce a detailed reform package.

There is much about the President's bill that is consistent with our principles. It would achieve nearly universal health insurance coverage. It would make insurance more affordable for small businesses and individuals. It would require employers to contribute for health benefits. It would encourage the continued growth of organized delivery systems. And it would reduce some of the administrative burden through insurance reform and electronic claims processing.

The President's bill also recognizes the role that large employers have played as active purchasers of care for their employees and would attempt to preserve that role by permitting companies with over 5,000 employees to function as corporate alliances with experience rating for their populations.

Despite the fact that there is a lot we like in this bill, unfortunately, we cannot support it as currently drafted. The most important reason is quite simply the corporate alliances don't work. As much as we would like to support the President's initiative, we cannot encourage enactment of a proposal that would transfer our employees to a largely public system and eliminate our role in providing them benefits.

Let me explain why we believe the corporate alliances are not a viable option. There is the risk that the corporate alliance could at any time be involuntarily and permanently terminated by the Secretary of Labor because the company failed in 2 out of any 3 years to keep its cost below the CPI, the company lost enough employees through spin-offs or down-sizing or by States opting for single-payer to drop below 4,800 employees, or for any other noncompliance. Even with involuntary termination, there is a risk that the company would be unable to keep its expenses, including the new administrative costs added by the bill, the 1 percent of payroll assessment and a host of other assessments, below the 7.9 percent of payroll amount that it would pay in the worst case for the regional alliance.

Corporate alliances would also be trying to manage their health care costs in an environment where the regional alliances now control 70 percent of the market, Medicare commanded another 13

percent, and the 1,200-odd corporate alliances divided up at most 17 percent. For almost every company, we think the risk and potential cost of operating a corporate alliance would be considered to outweigh the benefits.

How would we fix the corporate alliances? Let me focus on three suggestions today. First, the employer requirements and financing for health care, which should be national, and States should not be permitted to establish a single-payer system. State flexibility may be appropriate in areas such as oversight of health care services and licensing of hospitals and physicians.

However, State flexibility and rules governing employer responsibility or benefits would prevent multistate employers from providing equitable benefits for their employees across State lines.

Second, the influence of the regional alliance in the market should be greatly reduced. Size is one factor. We would like to see government employees and employees of firms larger than 500, or perhaps even a hundred, excluded from the regional alliance.

Reducing its size does not resolve all our concerns, however, since the remaining alliance with Medicaid and small business in it would still control at least 40 percent of the market. The regional alliance should be governed cooperatively and should be a relatively passive agent. It may even make sense to arrange for competing alliances if the underlying health plans were community rated and risk adjusted for this population.

Third, there should be intermediate penalties short of the atom bomb of involuntary termination. Where corporate alliances are trying to comply with the law, there should be a reasonable opportunity to work things out. We also do not believe it is necessary to apply premium caps to corporate alliances. We believe we already have the incentive to hold cost down and actually are doing that fairly successfully.

A new environment with standard benefits and a benchmark of a regional alliance would keep us under constant pressure to justify our continued existence by keeping our cost down.

I would like to conclude by saying that we appreciate the serious effort by this committee and by the President to solve our Nation's health care problems. Unfortunately, the thing we care most about, the corporate alliance, doesn't work as it is currently drafted. Ultimately, you must decide whether you want large corporations to continue to operate as organizers of health plans and innovators of strategies to improve quality and reduce cost.

If the answer is yes, we would like to work with you on redrafting the corporate alliance rule. If the answer is no, then we feel this bill should be redrafted and presented to the American people as a single-payer approach, because that is really what it would become.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you very much, Dr. Karrh.

[Testimony resumes on p. 681.]

[The prepared statement of Mr. Karrh follows:]

STATEMENT OF BRUCE KARRH

Mr. Chairman and Members of the Subcommittee:

My name is Bruce Karrh. I am a physician and Vice President of Integrated Health Care for the DuPont Company in Wilmington, Delaware. I am here today on behalf of the Corporate Health Care Coalition, a group of large, self-insured, multi-state employers recently formed to support the enactment of health care reform legislation. At present, the Coalition has 19 member companies -- all Fortune 200 -- who operate health plans for employees, their families, and retirees, covering over 2.8 million lives and providing over \$6.8 billion per year in health benefits. Each of our members has a sufficient employee population to qualify as a Corporate Alliance under the President's health care reform proposal.

Our Coalition is distinguished by its exclusive focus on issues of significance to large, self-insured employers. Our primary health care concerns are those of purchasers of health care for our employees and not those of vendors of insurance or health care products. Members of the Corporate Health Care Coalition have been in the forefront of efforts to ensure high-quality and cost-effective benefits for employees. We have extensive experience in designing, administering, and delivering employee health benefits; and are a major force today in ongoing efforts to restructure the health care delivery system.

SUPPORT FOR HEALTH CARE REFORM

As a Coalition, we are committed to the enactment of a comprehensive health care reform plan consistent with our principles by the end of 1994. We are pleased that the Congress is making progress toward that end and commend the President on his leadership in drafting and introducing a detailed reform proposal.

Our support for health reform is based on our belief that, properly designed, reform can improve access and control costs while enhancing the quality of care. To do this, we think health care reform must:

- slow the growth in health care costs;
- ensure that employers are responsible for their own employees;
- finance additional community health care costs where necessary through broad-based taxes;
- promote a continuing movement toward organized systems of care;
- rely primarily on private market mechanisms to restructure the market; and
- reduce inefficiencies and waste in the current system.

We believe a reformed health care system needs to retain a role for large employers who choose to continue providing health benefits for their employees. This role is necessary both as a source of continuing innovation in the system and as a benchmark against which to measure the performance of reforms in the rest of the

system. Let me be clear that member companies of the Corporate Health Care Coalition support at the very highest levels of the companies a continuation of employer-provided health benefits. Our shareholders are not prepared for us to simply write a check to some third party to provide health benefits for our employees.

For an employer-based system to work, we believe the following elements of the health care system are necessary:

- a requirement that all employers participate in financing health care for their employees and that all individuals enroll in plans;
- small employer purchasing groups that lower costs for small employers and that remain small enough themselves to avoid dominating the market;
- a marketplace with multiple purchasers of health care services, including a continuing role for large employers as purchasers;
- separate rating of large purchaser groups to enable purchasers to benefit from active management of their plans;
- national standards for employer-based plans (as now under ERISA) to allow uniform operations across state lines;
- an end to cost shifting from underfunded public programs, like Medicaid and Medicare, to private purchasers.

There is much about the President's proposal - H.R. 3600 - that is consistent with our principles.

The proposal would extend health insurance coverage to nearly every U.S. resident, improve the availability and affordability of health insurance to small business and individuals through insurance market reform and pooled purchasing, and require employers to participate in financing health benefits for their employees.

The proposal would encourage a restructuring of the health care delivery system with a growing emphasis on organized systems of care and a greater reliance on primary and preventive care.

The proposal would allow large corporate purchasers a variety of rating approaches for their insurance premiums.

Finally, the proposal would simplify health insurance by creating a standard benefit package with continuity of coverage and uniform electronic claims processing.

Despite these points of agreement, we are very concerned that the President's proposal does not create a viable role for employers to remain as active purchasers of health care for their employees. As much as we would like to be able to support this initiative, we cannot encourage the enactment of a legislative proposal which in our judgment would transfer our employees to a largely public system and eliminate our role in providing them health care benefits. Thus, we have come here today to offer some thoughts on how the options for large corporations in the President's proposal could be improved.

THE CORPORATE ROLE

As employers, we have been increasingly active in recent years in organizing health care for our employees to ensure them a high quality of care at a reasonable cost. Let me be quite frank: most employers have only taken on this role as active purchasers within the last five to ten years, and so our experience as a group is recent and we have not yet accumulated overwhelming quantitative evidence of reduced community health expenditures. We firmly believe, however, that we are having a substantial impact in our communities -- not only on the cost of health care, but on the way health care is delivered, the overall quality of care, and our employees' satisfaction with that care.

Some critics have suggested that large employers have merely shifted costs to others rather than helped slow the growth in national health expenditures. Today, however, Coalition member companies function not just as knowledgeable purchasers but as active shapers of the health care delivery system and marketplace. Our companies have begun to look for efficiencies in the way health care is delivered to their employees. As a first step, we have encouraged preventive care and educated our employees on how to use care. Many companies have structured financial incentives that encourage employees to enroll in the most cost-effective plans. In some cases, our companies have helped initiate statewide reporting on provider cost and quality and have assembled networks of cost-effective, high-quality providers that we encourage employees to use. Some of us have used our purchasing power to negotiate not only rate concessions but also practice parameters with physicians and hospitals. Many have also case-managed severe illnesses or injuries to ensure that the best services are provided at reasonable cost.

Let me describe briefly some of our member company projects that I think have helped advance national thinking on controlling costs and improving quality.

Hershey Foods Corporation helped Pennsylvania set up a system of state-wide reporting by hospitals and doctors of medical outcomes and charges. Hershey has used this information to identify and include in their networks high-quality, reasonable-cost providers at locations convenient for their employees.

Bell Atlantic Corporation has been able to get widespread employee enrollment in a new point-of-service plan in the Baltimore-Washington area that has reduced inpatient care, hospital admissions and benefits paid per admission. During the

first year, 72 percent of benefit payments have gone through this network, and Bell Atlantic's per beneficiary payments have declined 5.6 percent at a time when medical costs increased by 7.5 percent.

Atlantic Richfield Company has used case management to provide quality services at lower cost for employees who are severely ill or injured. For example, working together with the employee and his family, ARCO managers developed a home health care service skilled in AIDS treatment for an employee with late-stage AIDS so that the employee could spend his last months at home. The service enabled ARCO to avoid more than a quarter of a million dollars in hospitalization costs while improving the comfort of the patient.

As we read the President's proposal, we are struck by the similarities between the reforms the President wants to carry to the rest of the country and some of the innovative projects our member companies have worked on over the last decade. To the extent that the President's ideas have come from these activities, it is testimony to the important role that large companies can play as innovators and problem solvers in our health care system.

We plan to remain in this role, given the opportunity. However, were the President's proposal enacted as currently drafted, there would be little incentive for us to continue as purchasers; leading to the ironic result that the government would be extending programs like ours to the rest of the population while we are dismantling our existing programs for our employees. At the same time, the value of our expertise would be lost to the system.

CORPORATE ALLIANCES

Why would we be likely, under the Clinton proposal, to dismantle our existing plans? Perhaps the easiest way to view this issue is to anticipate the decision process in a large company once the bill is enacted.

As part of its decision whether to declare itself a Corporate Alliance, a company would weigh the risks or potential costs against the rewards or potential benefits of operating a Corporate Alliance. On the risk side, there are several factors that could cause the involuntary termination of a Corporate Alliance, forcing a company's employees into the Regional Alliance permanently.

- First, if the Corporate Alliance failed to keep its annual increases in per capita expenditures below the "general inflation factor" (e.g. CPI) for two of the last three years, the Alliance would be terminated.
- Second, should the employer lose enough employees through spinoffs or downsizing to fall below 4800 employees on any January 1st, the Alliance would be terminated.

- Third, if a state elected to be a single payer state and to cover Corporate Alliance employees, the Corporate Alliance would be terminated in that state. If that single payer election or the sum of all state single payer elections caused the Corporate Alliance population to drop below 4800 employees, then the Alliance would be terminated nationwide.
- Finally, the Secretary of Labor could terminate a Corporate Alliance for failure to comply with the statutory requirements.

Should a Corporate Alliance manage to avoid these pitfalls, it would have to maintain costs that are below the Regional Alliance cap on employer contributions (currently set at 7.9% of payroll) to justify its existence. This means that a Corporate Alliance's expenses for comprehensive benefits plus administrative costs and the 1%-of-payroll Corporate Alliance assessment could not exceed 7.9% of payroll.

The bill would impose additional costs on companies that establish Corporate Alliances, including the accumulation of reserves to cover health benefit costs, new reporting and disclosure requirements, greater liability for participant lawsuits, contributions when necessary to a national Corporate Alliance insolvency fund, and possible contributions during the transition period before 1998 to a National Risk Pool for the uninsured.

On the reward side, a company that maintained a Corporate Alliance could benefit from the greater employee loyalty and morale associated with company health benefits, assuming that the company would be able to provide a higher level of personal service and quality medical care than the Regional Alliance. The company could also benefit from separate rating of its own population, from aggressive purchasing activities, and from any special health promotion, wellness, and patient management activities it undertakes.

To benefit from its own purchasing, the Corporate Alliance would need enough presence in the marketplace to extract practice or price concessions from providers. Corporate Alliances, under the President's proposal, however, will become relatively small purchasers in a marketplace dominated by two public entities: the Regional Alliance and Medicare. Table 1 (attached) prepared by the Employee Benefit Research Institute (EBRI) shows the proportion of the population in the Regional Alliances on a state-by-state basis - assuming all employers with more than 5000 employees set up Corporate Alliances. The Regional Alliances in every state would control at least 60 percent of the population, and, on average, would control 70 percent. Nationwide, another 13 percent would be in Medicare, leaving roughly 1200 Corporate Alliances to divide up the remaining 17 percent of the population. The imbalance is even greater when marketshares are measured in terms of expenditures, since Medicare and Medicaid alone account for nearly half of all third-party health care spending.

Given the balance of risks and rewards, the likelihood that a company will make the investment to form a Corporate Alliance under these rules is quite small. Even were some companies to risk operating a Corporate Alliance, we believe it would only be a

matter of time until they encountered one of the pitfalls and were brought into the Regional Alliances.

In summary, the problems with the Corporate Alliance structure from a company standpoint are:

- 1) Enforcement overkill -- the penalty for Corporate Alliance "failure" is immediate and permanent revocation of the right to be a Corporate Alliance -- there is no opportunity to come into compliance and no intermediate penalty.
- 2) Ultimate state control -- the state single-payer option gives individual states final authority over whether a national employer can operate their own Corporate Alliance in the state - and in some cases nationwide.
- 3) Double jeopardy on costs -- employers are penalized twice for cost increases: by paying the higher costs in the first place and by losing their Corporate Alliance if they exceed the premium caps.
- 4) Unfair competition -- Corporate Alliances have to achieve their savings as a small private purchaser in a marketplace dominated by two large public purchasers.

RECOMMENDATIONS

While a number of features of the President's proposal cause us some concern, we are most concerned about those that would prevent us from maintaining high quality health care programs for our employees. For this reason, we will focus in our remarks here on a few modifications to the proposal which we believe would help make the Corporate Alliance a viable option for large employers.

1) State Flexibility

We cannot stress enough that multistate employer plans should not be subject to state-by-state controls on their health plans. Multistate employers cannot continue providing equitable and uniform benefits to their employees if states can impose their own requirements on their plans.

While we support the notion of allowing states to retain the authority to regulate health care providers, we do not believe this idea should lead to granting states new authority to impose a single-payer system over every aspect of the health care system. For one thing, we are not convinced that the additional authority a state gains from a single-payer declaration is anything more than the authority to force Corporate Alliance employees into the state system. Although states maintain that a single-payer system

would enable them to control costs through direct payment of providers, in fact, the President's plan would already give states considerable control over providers and provider reimbursement. States could achieve the goals of single-payer proponents even without the single-payer option.

Since health care is inherently local, we believe it is appropriate for states to oversee the health care delivery system, e.g., licensing practitioners or certifying hospital quality. We do not believe it is appropriate or constructive for each state to have unique benefit standards, employer requirements, data reporting forms, or financing schemes.

2) Market Structure and Alliance Size

We believe the size of the Regional Alliance should be greatly reduced. Smaller Regional Alliances would enable a balanced array of multiple purchasers to prevent health plan concentration and foster competition. Any purchaser who dominates the market in a region will be able unilaterally to guide the responses of sellers.

Even an Alliance serving exclusively individuals and small firms with fewer than 100 employees (assuming Medicaid and public employees were otherwise provided for) would cover nearly one-third of the population overall (see Table 2). Adding Medicaid would raise the Alliance population share to nearly 40%, and increasing the included firm size to 1,000 employees would raise it further to 55%. Reducing the size of the Regional Alliance creates some tough questions about how to pool the risk of various populations, which we are willing to help resolve.

We are also concerned that the extensive subsidies associated with a large Regional Alliance may be inadequately financed in the President's proposal, creating pressure to increase assessments on Corporate Alliances. Underfinancing could result from two factors: the fold-in of a revenue-starved Medicaid program, and subsidies to all employers to reduce their health costs to 7.9% of payroll -- below today's average employer cost. Alternatives should be explored to finance Medicaid adequately and reasonable limits should be placed on subsidies to medium and large employers in the Regional Alliance.

3) Corporate Alliance Requirements

Failure of a Corporate Alliance to meet requirements of the Secretary of Labor or to adequately control costs should be met with intermediate penalties, incentives to comply, and an adequate period to bring the Alliance up to standard. The Secretary's discretion to terminate the Alliance should be limited to repeated compliance failures, lack of a good

faith effort to comply, or permanent Alliance insolvency. Companies that become Corporate Alliances also should have the option to retain this status when their population drops below the threshold level, down to some practical minimal level.

We do not believe premium caps are either necessary or constructive for Corporate Alliances. First, Corporate Alliances, as both payers and Alliances, would already have the bottom-line incentive to hold their costs down. Second, Corporate Alliances would be in a new environment with uniform benefit standards, expenditure targets, and the benchmark of a Regional Alliance with a 7.9% payroll cap on employer contributions. They would be under constant pressure to demonstrate greater cost control than the Regional Alliances to justify their continued operation as a Corporate Alliance.

CONCLUSION

The President's proposal overall makes a serious commitment to address many of the problems that plague our health care delivery system and drive up health care costs. There are major aspects of the proposal that would be helpful to us as health plan sponsors and purchasers. In particular, we support the importance of an employer obligation to finance health care for their employees, and the emphasis on more cost-effective delivery of care.

Unfortunately, the way the Corporate Alliance option is structured in the proposal, the member companies of the Corporate Health Care Coalition do not believe they would be able to operate effectively as health plan sponsors and purchasers were this proposal enacted in its current form.

Ultimately, this Committee and other Members of Congress must decide whether they want large corporations to continue to operate as organizers of health plans for their employees and innovators of strategies to improve quality and reduce cost. If the answer is yes, then the rules for Corporate Alliances in H.R. 3600 need to be redrafted to encourage large corporations to establish them, and to enable them to continue to operate successfully into the future without the imminent threat of termination. If the answer is no, then this bill should be drafted and presented to the American public as a simple single-payer approach, without the illusion and language of employer-based health benefits and Corporate Alliances that are intended to disappear.

The ultimate concern for all of us is our employees. We believe our employees as a group are satisfied with and value highly their current health benefits. Given the choice of continuing to receive these benefits through company plans or joining large regional alliances serving millions of people, we believe our employees would overwhelmingly choose to continue what they currently have. It will be difficult to justify to them terminating their high-quality coverage and service only to attempt to replicate this coverage through large public programs.

TABLE 1

Estimate of number of Americans in Alliances, By State

<u>State</u>	<u>Population in Alliance</u>	<u>Percent of Population in Alliance</u>	<u>Total Population</u>
Alabama	2,897,856	69.8%	4,152,693
Alaska	408,700	85.9%	475,793
Arizona	2,434,731	68.9%	3,536,022
Arkansas	1,618,524	66.6%	2,431,733
California	22,717,739	75.4%	30,140,000
Colorado	2,264,445	68.6%	3,301,898
Connecticut	2,278,078	68.2%	3,338,667
Delaware	421,023	60.4%	696,853
District of Columbia	415,015	78.9%	525,759
Florida	8,901,486	67.8%	13,120,000
Georgia	4,032,458	65.2%	6,185,082
Hawaii	829,879	77.3%	1,073,322
Idaho	728,632	70.5%	1,033,583
Illinois	8,010,592	68.2%	11,750,000
Indiana	3,604,368	65.1%	5,533,281
Iowa	1,927,547	68.4%	2,819,317
Kansas	1,770,470	69.2%	2,559,502
Kentucky	2,492,734	69.3%	3,596,914
Louisiana	2,950,952	70.6%	4,181,983
Maine	886,712	73.4%	1,208,016
Maryland	3,367,517	72.1%	4,668,497
Massachusetts	3,978,347	68.7%	5,788,645
Michigan	6,210,320	67.0%	9,265,961
Minnesota	3,056,134	69.9%	4,370,391
Mississippi	1,826,364	68.3%	2,672,263
Missouri	3,372,448	67.5%	4,993,067
Montana	622,703	76.8%	811,050
Nebraska	1,131,826	70.1%	1,614,753
Nevada	869,993	71.3%	1,220,756
New Hampshire	763,122	69.3%	1,101,226
New Jersey	5,380,184	69.5%	7,738,067
New Mexico	1,173,043	77.1%	1,521,191
New York	12,977,721	72.7%	17,860,000
North Carolina	4,257,764	65.3%	6,523,154
North Dakota	481,056	79.2%	607,471

Assumes all Employers with over 5,000 Employees Insure Their Employees and Dependents Through a Corporate Alliance

<u>State</u>	<u>Population in Alliance</u>	<u>Percent of Population in Alliance</u>	<u>Total Population</u>
Ohio	7,475,986	67.5%	11,070,000
Oklahoma	2,134,462	68.1%	3,132,370
Oregon	2,117,144	71.3%	2,967,899
Pennsylvania	8,164,417	67.3%	12,130,000
Rhode Island	655,477	69.2%	947,440
South Carolina	2,316,120	65.9%	3,512,930
South Dakota	506,719	74.5%	680,204
Tennessee	3,142,134	65.7%	4,782,738
Texas	11,544,251	68.8%	16,770,000
Utah	1,208,952	71.7%	1,685,698
Vermont	419,556	72.6%	578,077
Virginia	4,097,395	69.5%	5,893,634
Washington	3,566,755	72.9%	4,893,273
West Virginia	1,239,827	67.8%	1,829,958
Wisconsin	3,519,080	71.0%	4,953,968
Wyoming	345,707	74.8%	461,987
Total	173,514,461	69.8%	248,700,000

Assumes all Employers with over 5,000 Employees Insure Their Employees and Dependents Through a Corporate Alliance

TABLE 2

Estimate of the Number of Americans in Health Alliances

Minimum Employer Size Allowed for Opting Out of the Alliance	Scenario					
	Medicaid-Outside Public-Outside		Medicaid-Inside Public-Outside		Medicaid-Outside Public-Inside	
	Number (millions)	Percent of Pop. ^a	Number (millions)	Percent of Pop. ^a	Number (millions)	Percent of Pop. ^a
100	80.60	32.4%	95.84	38.5%	109.41	44.0%
500	108.18	43.5	124.66	50.1	132.90	53.4
1,000	119.16	47.9	136.03	54.7	141.57	56.9
5,000	139.02	55.9	156.54	62.9	148.35	59.6
					173.51	69.8

^aTotal population: 248,704,705

Estimates are Based on Various Scenarios Regarding Minimum Employer Size Allowed for Purchasing Coverage Outside the Alliance and Whether Public Employees and Medicaid Recipients Purchase Coverage Inside or Outside the Alliance

Mr. WAXMAN. Ms. Mazo?

STATEMENT OF JUDY MAZO

Ms. MAZO. Thank you, Mr. Chairman, members of the subcommittee. I am Judy Mazo from the Segal Company. Robert Georgine, who is the chairman of the National Coordinating Committee for Multi-Employer Plans was, unfortunately, at the last moment unable to attend, and asked me as one of the technical advisers to the group to appear before you to present our views.

Very briefly, I just want to make two points. One is to say how strongly the Coordinating Committee does endorse the President's proposal as embodied in H.R. 3600 as introduced. In particular, we strongly support the employer mandate, which we feel is essential both to eliminate the cost shifting that is creating such enormous pressures on our plans and employers that do pay for health insurance and to avoid the unfair competitive disadvantage that our contributing employers have been suffering under.

Aside from that I would like to say that we very strongly appreciate the administration's acknowledgment of the need to maintain flexibility for multi-employer plans to continue providing the kind of specially tailored coverage and services for their members and participants that they have developed over the 40 or so years of their tradition.

In acknowledging the ability and creating flexibility for those plans to serve as sponsors of corporate alliances, while we acknowledge that there are a number of impediments and problems to maintain the corporate alliances effectively, we think it is possible with some refinements in the legislation.

We want to point how crucial it is to these participants to maintain the kinds of plans they have now. Particularly, for example, there are many multi-employer plan participants who would not get, who would lose employer paid coverage under the Health Security Act if they were no longer able to be represented through their multi-employer plans. This is because the proposed law would require employers to pay a premium, a full premium only for people who work for any given employer as much as 120 hours a month, and even a partial premium only if the person works as much as 40 hours a month.

This is reasonable from an employer recordkeeping point of view, but in the volatile industries where many multi-employer plan participants work, such as construction or entertainment, that means many people who in effect are working full-time, but may not work as much as even 40 hours a month for a given employer, would get no employer-paid premium.

An actor who is hired to work for a day or two doing voice over for a commercial isn't working 40 hours for that producer. In fact, that person may do several commercials in the month, if they are lucky, but never work as much as 40 hours for any one producer. That person probably now has full paid coverage, 100 percent, for himself and his family through the Screen Actors Guild or AFTRA. They would not have employer-paid coverage without those plans being able to continue.

And so it is that kind of—that is the strongest reason. There are many other features where this is, in effect, a niche where we feel

the multi-employer plans need to continue providing those services, and we are very glad the administration has acknowledged that and recognized that function.

Thank you.

Mr. WAXMAN. Thank you very much.

[Testimony resumes on p. 694.]

[The prepared statement of the National Coordinating Committee for Multiemployer Plans follows:]

STATEMENT OF

NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS

Mr. Chairman and Members of the Subcommittee, I am Robert A. Georgine, Chairman of the National Coordinating Committee for Multiemployer Plans. The Coordinating Committee, also often referred to as the NCCMP, was formed shortly after the enactment of ERISA to present, explain and protect the interests of jointly-managed multiemployer pension, health and welfare benefit plans in the development of federal policy affecting those plans and, most importantly, the millions of American workers and families for whose benefit multiemployer plans operate. I am pleased to appear before you today to talk about multiemployer plans' interest in a federal policy initiative whose importance to the benefit plan community could end up eclipsing even ERISA: national health care reform.

Last month you received testimony from me in my capacity as President of the Building and Construction Trades Department of the AFL-CIO, laying out in some detail how multiemployer plans operate, and what their objectives are, generally, for national health reform. Today I want to turn more specifically to the President's proposal, as embodied in H.R. 3600, and to talk about how multiemployer plans both within and outside of the construction industry are reacting to it generally.

I am pleased to report to you that the Coordinating Committee warmly supports the President's proposal. Of all of the reform approaches that have been suggested or offered, the Health Security Act appears to us most likely to achieve the health care objectives that multiemployer plans are seeking: universal coverage at reasonable cost, without compromising the quality of care that individuals receive. Now that the President's program has been reduced to legislative language, we have been able to confirm that it does create positive opportunities for multiemployer plans to protect and advance the interests of their participants as the nation moves toward those widely-embraced goals.

I. General Issues

I would like to start by discussing a few key issues raised by the President's proposal that we feel merit special attention.

Universal Coverage

We believe that this country can and should guarantee universal health coverage for all of its citizens. Every American should know that he or she will receive appropriate health care when it is needed -- including preventive care, given before more drastic and more expensive crisis care is needed. That, we believe, is a basic value for a civilized society. It was the commitment to that principle that moved unions and employers to adopt multiemployer health and welfare plans in the first place, so that union-represented workers in the industries supporting the plans could be guaranteed that they and their families would have health coverage even as the employees go from job to job, and even though many of their employers might be too small to provide good health coverage economically.

Building on our country's time-honored system of employment-based benefits, we agree with the President that requiring all employers to pay for most of the cost of covering their employees is the most realistic, and certainly the fairest, way to assure the achievement of universal coverage within the time frame needed for action on health care reform.

This leads to our "selfish" reasons for supporting universal coverage through an employer mandate: it will level the competitive playing field for employers that live up to their social responsibilities and provide health coverage for their work forces.

Much criticism of the President's program has focused on the potential impact on employers that do not now provide health coverage for their employees. To us that is the wrong perspective. We look at the proposal for what it would do for employers that are now providing health coverage, particularly through multiemployer plans. And for those companies, the President's proposed employer mandate is good news.

While most multiemployer plans, albeit struggling mightily, have generally been able to keep health coverage in place for most of their participants and their families, the existing gaps in health coverage in our population have taken their toll. The primary villain is cost shifting.

You know what this is about: people without health coverage receive health services, usually when they are at a crisis and often at emergency rooms, which is the worst point for them personally and for the economics of the system generally. To recoup their losses on those unpaid bills, hospitals and other health care providers increase charges to multiemployer plans and others that pay their bills.

To add insult to injury, some of the unpaid health care bills that have shown up in charges to our plans have been for services to people working for companies that compete with our contributing employers, which have been able to undercut them competitively by refusing to provide benefits for their employees.

So we see the employer mandate in the Health Security Act as a welcome answer to our need, as responsible payers for health care, for relief from this aspect of the uncompensated-care cost burden. And, to the extent that the law requires all employers to contribute on an equal basis toward their employees' health coverage, it would correct the current unfair bias against the good, responsible employers who pay their fair share of the nation's health care bills by contributing to multiemployer health plans.

Comprehensive Benefits.

To give meaning to the guarantee of universal health coverage, the President's program spells out a detailed schedule of comprehensive benefits that would have to be provided. Whether those are all of the "right" benefits, and whether the detail with which they are covered leaves adequate room for responsible plan management through innovative design, are technical details that will, we are sure, be explored thoroughly in the coming months. It is worthwhile to point out here how important it is that the right to health care that Americans will be promised be a meaningful one that preserves the kind of health care safety net many families covered by multiemployer plans now enjoy. Cutting the benefit package back to a bare-bones level would, we fear, deny promising, often cost-beneficial health care options to many middle and working class families if their health insurance does not make it possible for them to pay,

for instance, for outpatient prescription drug therapy or early intervention at the onset of a health problem.

For these reasons we urge you to resist the pressures that will doubtless be brought to bear to strip out much of what the President has proposed for the comprehensive package. If it is necessary to economize on health care reform, the savings should not come from dropping protections needed by America's families.

Tax Favored Benefits.

We believe that health coverage can only be kept affordable for our plans' participants if it continues to be tax deductible for their employers, and tax exempt to them. We cannot understand the logic of those who say that American workers will become better or more sophisticated at "shopping" for health care if the price of their health plan coverage is increased, which is all that a tax on benefits would do. If that reasoning were correct, the experience with health care inflation over the last decade or so would have solved the problem for us.

What we fear is that taxing health coverage would lead to a drop in the quality and depth of health coverage, particularly for the kinds of working and middle class families that our plans cover, and ultimately to a two-tier system of health care. We do not want to see an America in which our outstanding medical institutions are reserved for the rich of all nations, while most Americans are relegated to cut-rate clinics.

Proponents of taxing workers on their health benefits treat medical care as if it were a luxury item, like a yacht or a beach house. They seek, in effect, to punish workers who have earned health benefits coverage above a certain level. We reject this view. Health benefits coverage is not a luxury. It is a necessity -- for personal health and financial security, as well as for the Nation's Welfare. Workers who do not have comprehensive health care will not be productive over the long run. The United States cannot meet the global competition with a workforce whose health care needs are not being met. Instead of restricting health benefits

coverage through taxation, the Government should be raising the level of health coverage for all workers.

Frankly, the President's plan does not give us all we want in this regard. Starting in 2004, employees would have to pay tax on employer-paid benefits that are not in the statutory comprehensive package. This will, of course, be less of a problem if, as we urge, the comprehensive package remains as broad as the President is now proposing. If vital elements of are dropped from that package so that working families will not have complete health care protection without larger employer-paid supplements, taxing that supplemental coverage could cause real hardship.

Beyond this, however, we urge you to reject proposals to cut the favorable tax treatment for health coverage back even further than the President has suggested. The Health Security Act would, for example, enable multiemployer plans to continue paying 100% of the premium for all of their participants and their families without creating tax liabilities for them. Aside from benefiting those families directly, this is likely to save at least as much as it would cost in administrative complexity, which is a prime threat in any scheme to measure and tax something as variegated as health coverage.

But our concern with proposals to tax health coverage beyond a set minimum stems from a much simpler source: it would mean that many multiemployer plan participants would, at least in the short term, suffer a net cutback in benefits as the result of the enactment of national health reform. That is not acceptable to us, as their representatives. We suggest that it should not be acceptable to you, as responsible national leaders, either, because no national health care reform is likely to succeed unless the general public recognizes it as an improvement for them. That will not be the reaction of multiemployer plan participants and other workers if, for the immediate future, national health reform from their perspective means little more than a tax increase.

II. The Role of Multiemployer Plans

The NCCMP particularly applauds the President and his national health reform team for acknowledging and accommodating the special role that multiemployer plans can and should play in a reformed national health care system on behalf of their participants. The preservation of multiemployer funds under the reformed system is consistent with the President's policy of not leaving workers worse off. And, it makes sense not to unnecessarily upset a health benefits structure that works and so closely resembles the pooling structures, or alliances, which the President's bill would create.

The prime distinction of multiemployer plans is that they provide continuous health coverage to workers as they change jobs, moving from one contributing employer to another. In effect, all of the contributing employers are treated as a single employment unit, who typically contribute at uniform rates to provide a common package of health benefits to the covered workers and their families. This portability or seamless coverage is essential for workers in mobile, seasonal industries like building and construction, entertainment, and longshore.

For these workers, the multiemployer plan serves as a central source of health coverage and a central repository for the employer contributions that pay for the coverage. Without this pooling mechanism, health coverage would not be feasible for many of them.

The pooling function of the multiemployer plans is crucial not only because of the transient nature of many of their participants' employment, but also because the small employers for whom most of them work could not, or would not, maintain separate health plans. The multiemployer plans enjoy economies of scale in administration and combined purchasing power not available to the individual contributing employers.

The plans' joint labor-management boards of trustees, working with professional staff and advisors, are responsible for plan design and administration, including collecting the required

employer contributions and managing the reserves. Participating employers have to do little more than pay the contributions when they are due, with verifying information. The trustees use the pool of collectively-bargained contributions and the pool of covered workers and families to negotiate better terms with insurers and health service providers than the participating employers could achieve on their own.

Thus the parallels between multiemployer plans and those of Health Alliances under the Health Security Act are striking. In effect, the Act proposes to extend the multiemployer plan concept to the population at large. In so doing, however, the drafters have been wise enough not to destroy the original model. In effect, the Administration recognizes that our plans have come up with answers that work, so its proposal takes steps to let our good work continue. We appreciate that, of course, and urge you to support that recommendation.

In our view, making it possible for multiemployer health plans to continue serving their participants within a reformed national health care system could be an important way of helping to preserve the quality of care and service that those families receive. But multiemployer plans will be needed to play an even more crucial: to protect their participants' right to employer-paid health coverage.

For technical reasons, some multiemployer plan participants could slip through gaps in the proposed statutory requirement that employers help pay for health coverage for all of their employees. That is because the law would only require a full employer premium payment for an employee who is considered "full time", which generally would mean someone who works for that company at least 120 hours a month, and it would not require an employer to contribute anything for someone whom it employs for less than 40 hours a month. In other words, employers would be required to pay as little as one-third of a monthly premium for a part-time worker, but nothing smaller. This is not necessarily unreasonable, in light of the paperwork needed to determine, make, account for and enforce the statutory premium payment obligation.

The problem is that in many industries where multiemployer plans predominate, such as construction or entertainment, employees may move from job to job so frequently that they rarely would be considered full time with any one company. Many of them may not even meet the part-time test of 40 hours a month per employer very often, even though they are in fact fully employed, or close to it. Related to this is the fact that many multiemployer plan participants may work much more than a standard full-time week for part of the year, with the level of available work dropping drastically at other times. Under the Health Security Act, and without a multiemployer plan to intervene, for much of the time these people would not be entitled to employer contributions toward their health insurance. Although they and their families now have full employer-paid health coverage through their multiemployer plans, under health care reform they would have to pay for it themselves, with government aid if they apply for it and their family income is low enough to qualify.

This of course is the very problem that multiemployer plans were invented to solve. Happily, the Health Security Act enables them to continue meeting these and other special needs of their participants, by offering them several alternative ways to continue to offer meaningful services to the people they are now covering.

Multiemployer Corporate Alliance. One way that some multiemployer plans could function would be by sponsoring a Corporate Alliance through which their participants and their families continue to obtain basic health coverage. Multiemployer plans that do not currently cover 5,000 active participants could, under H.R. 3600, band together with related plans to meet that size threshold in order to qualify for Corporate Alliance status.

Most multiemployer plans offer benefits that are similar, although not identical, to the statutory comprehensive benefit package. Many offer at least one HMO option, in addition to the fund's basic fee-for-service plan. Plan eligibility requirements would have to be modified somewhat, as almost all multiemployer plans build in a waiting period for coverage, which gives the plans time to obtain reliable data on people working in covered service from their employers. But in the main multiemployer plan designs would not have to be dramatically changed, to fit

what would need to be offered through a Corporate Alliance. More importantly, since almost all multiemployer plans now provide 100% employer-paid coverage for eligible employees and their families, plan funding arrangements generally would not need major changes in order to be sure of meeting the law's new minimum requirements. Seamless health coverage for multiemployer plan participants would remain in place.

A bigger challenge will be to manage the plans offered through the Corporate Alliance effectively enough to maintain the costs at levels competitive with what similar coverage would cost if obtained through the Regional Alliance system. But that is a challenge we welcome, because it would mean that national health reform is succeeding in making good health care available at more manageable cost than what we in the private sector have been able to achieve on our own.

Multiemployer Plan Within a Regional Alliance. The proposed Health Security Act also enable multiemployer plans to elect to serve as the employer for their participants, within a Regional Alliance through which the participants and their families would be covered. That is, the multiemployer plans would not, as in a Corporate Alliance, be responsible for managing the delivery of basic health coverage. Instead they would handle the employee-enrollment and premium-paying functions on behalf of their contributing employers.

As at present, with the multiemployer plan serving as the vehicle for its participants' coverage through the Health Alliance, all service for contributing employers would be treated as service with a single employer. Using the multiemployer plan as the umbrella mechanism for determining their employment status would also ease administrative and billing procedures for the Regional Alliance. It might also make it easier to coordinate any supplemental and related welfare benefits that employees receive from their multiemployer plans, such as life insurance and short-term disability coverage, with the basic health coverages delivered through the Regional Alliance plans.

In general, employees enrolled for health coverage through a multiemployer plan would have at least the same protections and opportunities as other employees. The multiemployer plan might also assist its participants in dealing with the Regional Alliances and the health plans in which they enroll (e.g., claims disputes, support in seeking authorization for particular services or explaining why they are not authorized, communications about plan content and selection, problems with providers). This educational/ombudsman role should not only smooth the participants' path through the new health care structure, but it could also make the multiemployer plan a useful channel for employee communications on such matters as health promotion, wellness programs, evaluating providers, etc., which might be initiated either by the plan or by the Alliance.

Supplemental Benefits Only. The sponsors of other multiemployer plans might decide that it is simpler and more cost-effective for the plan to withdraw from the arena of providing and funding basic health coverage. This is most likely in industries where there is a common pattern of relatively stable employment so that workers would generally work for one company long enough to qualify for employer-paid coverage under the terms of the law. The bargaining parties might choose to rely on the mechanisms set up by the law to assure proper treatment for workers generally, focusing their energies and resources on other benefits -- including supplemental health and welfare benefits -- or on other features of the employment relationship. This is how multiemployer plans operate quite successfully in Canada. I am glad that the President's proposed Health Security Act makes this alternative, as well as the more activist approaches, fully available to the sponsors and trustees of multiemployer health and welfare funds.

III. Next Steps

Our endorsement of the program for multiemployer plans within national health care reform as spelled out in H.R. 3600 does not mean that we think the job of statutory refinement is complete. Our professional staff is continuing to review the proposed statutory language and design, to identify areas where further clarification or modifications would make the scheme

operate more smoothly. One area that we are in the process of reviewing closely, for example, relates to how, precisely, a multiemployer plan would function within a Regional Alliance. We are also looking at whether the tools available to multiemployer plans to collect employer contributions would need to be strengthened. I am sure that other technical matters will come to our attention as our staff combs the voluminous proposed legislation.

Mr. Chairman, I would welcome the opportunity to have our technical specialists sit down with your staff, as soon as they are able, to go over these items and devise workable solutions to them, so that together we can move this important legislation toward an early enactment.

Mr. Chairman, Members of the Subcommittee, I would be happy to take any questions you may have for me.

Mr. WAXMAN. Mr. Williams?

STATEMENT OF ANTHONY C. WILLIAMS

Mr. WILLIAMS. Mr. Chairman, my name is Tony Williams. I am the Director of the Retirement, Safety and Insurance Department for the National Rural Electric Cooperative Association. I am very pleased to have the opportunity to testify this afternoon.

We applaud President Clinton's commitment to reforming the health care delivery and financing system, and we believe the administration's proposal is a vital first step in addressing the problems that exist in this critical area.

Before turning to the subject of today's testimony, however, I would like to just briefly digress. We believe that the biggest challenge facing the Congress and the administration with respect to health care reform is how to make it work in rural areas. Rural areas share all the problems encountered in urban areas, but in addition to that they face even bigger problems of inadequate resources, inadequate infrastructure and personnel to provide medical care. We urge Congress and the administration to continue to seek ways of solving these critical problems, and in that respect we pledge our assistance based on our experience in rural areas.

Back to the issue at hand. We agree with the administration that there should be corporate health alliances. We believe this for three reasons.

First of all, the employer has a far greater interest in the health, the moral and the productivity of his employees and of the State certified health plan or State-established regional alliance.

Second, an employer knows his employees better than any unrelated third party and is better suited to design a plan to meet their needs.

Third, we believe that any health care plan should encourage establishing wellness and life-style programs and other innovations to control cost, and we believe that this is best accomplished by those who will benefit directly from these programs and that would be, namely, the employer.

A sense of our ability, the rural electric's ability to establish corporate health alliance option is tempered by the severe disincentives included in the administrative proposal—the administration's proposal. There are significant Federal subsidies applicable to regional alliance employees which are not available to corporate alliance employers. Health care premium payments for regional alliance employers are capped and Federal Government subsidies for any shortfall are available in contrast to employers operating corporate health alliances are subject to no cap and no Federal subsidy.

Originally, all corporate alliance employers were subject to a tax equal to 1 percent of payroll. This provision has now been changed to exempt multi-employer corporate alliances. In contrast, regional health alliance employers are directly assessed an amount generally equal to 1.5 percent of health premiums.

I would like to raise one particular issue that is specific to rural electric cooperative health alliances. Our alliances, unlike most health alliances, would be made up of a number of small employers who would otherwise be available for Federal subsidies. We believe

that an unfair playing field would significantly disadvantage our members and their employees.

As a general matter, we believe all disincentives with respect to corporate health alliances should be eliminated. Employers currently play and will continue to play an important role in the health care system, and their operation should not be hindered by the unequal treatment accorded to corporate health alliances.

We reiterate our willingness to work with the committee in any way possible to modify the administration's proposal and to create a level playing field that would permit employers acting as corporate health alliances to design and administer health plans for their employees.

Thank you.

[The prepared statement of Mr. Williams follows:]

STATEMENT OF
NATIONAL RURAL ELECTRIC COOPERATIVE ASSOCIATION

Introduction

Mr. Chairman, my name is Anthony C. Williams and I am the Director of the Retirement, Safety, and Insurance Department for the National Rural Electric Cooperative Association ("NRECA"). We are pleased to have this opportunity to share our comments regarding the treatment and operation of corporate alliances, as described in the Administration's health reform proposal.

NRECA

NRECA is the national service organization of the approximately 1,000 rural electric service systems operating in 46 states. These systems serve over 25 million farm and rural individuals in 2,600 of our nation's 3,100 counties. Various programs administered by NRECA provide pension and welfare benefits to over 125,000 rural electric employees, dependents, directors, and consumer members in those localities.

NRECA has for many years been deeply interested in health care policy. In this regard, NRECA has sponsored studies such as "Health Care Needs, Resources and Access in Rural America", "The NRECA Survey of Health Coverage in Smaller Firms", "The NRECA Plans and the Minimum Health Benefit", and "Managed Care Plans in Rural America". NRECA is currently updating "Health Care Needs, Resources and Access in Rural America", for distribution in late January or early February of 1994.

Our studies of health care financing and delivery systems in rural areas have given us an appreciation for the complexity of these issues. We recognize that we are still learning about health care reform and the possible means of transforming our current health care system. We also are still learning from NRECA members about their views on these important issues. Accordingly, we anticipate modifying and refining our views as the reform process moves forward.

We applaud President Clinton's commitment to reforming the health care delivery and

financing system. The Administration's proposal is a vital first step in addressing the problems that exist in this critical area.

Corporate Alliances - In General

We are testifying here today regarding NRECA's reaction to the idea of corporate alliances as set forth in the Administration's proposal. Before turning to that subject, however, we would like to digress briefly. Perhaps the greatest challenge facing Congress and the Administration with respect to health care reform is how to make reform work in rural areas. Rural areas share the problems encountered by urban areas but in addition face even bigger problems: inadequate resources, infrastructure, and personnel to provide medical care. We urge Congress and the Administration to continue to seek ways of solving these critical problems. In that respect, we pledge our assistance based on our experience in rural areas.

With respect to the issue for today, *i.e.*, corporate alliances, a brief description of the corporate alliance concept is appropriate as an introduction to a discussion of our reaction. Under the Administration's proposal, in general, employers and individuals purchase health coverage from state-certified health plans offered through regional alliances. A regional alliance is an entity established by the state to serve as an intermediary between the health plans, on the one hand, and the employers and individual insureds on the other hand.

There is an exception from this general structure for corporate alliances. Generally, there are three types of entities eligible to be a corporate alliance: a large employer with over 5,000 full-time employees, a multiemployer plan with over 5,000 active participants, or a group of rural electric or telephone cooperatives that provide health coverage to over 5,000 full-time employees. If such an entity elects to be a corporate alliance, the regional alliance system does not apply to the entity's full-time employees. Instead, the corporate alliance becomes responsible for the health coverage of such employees. The corporate alliance may design its own self-insured health plans or contract directly with one or more state-certified health plans. Thus, briefly stated, the corporate alliance system provides an employer with far more control

over the design and administration of the health plans provided to its employees than does the regional alliance system.

Should Corporate Alliances Exist?

The fundamental question is whether corporate alliances should exist or whether the regional alliance system should be exclusive. We agree with the Administration that there should be corporate alliances. The basic reason for this belief is simple. An employer has a far greater interest in the health, morale, and productivity of its employees than does a state-certified health plan or a state-established regional alliance. Accordingly, it is only logical that the employer, and not some unrelated third party, would be the most responsive to the needs of the employer's employees in designing and administering a health plan.

More specifically, an employer knows its employees better than any unrelated third party and thus is best-suited to design a plan to meet their needs. An employer's knowledge of its workforce is also important in shaping the most appropriate system of health plan administration. Moreover, an employer's interest in its employees' morale will result in a more responsive administrative system.

In addition, we believe that the nation's health care system should encourage the establishment of wellness programs and other means of improving health. The system should also encourage innovation in all areas including cost-containment and quality of care. The corporate alliance system creates tremendous incentives for such innovations and improvements by putting control of the system in the hands of those who will benefit the most from improvements: the employer and its employees. Putting control in the hands of distant third parties can only slow the rate of improvement in health plans.

We at NRECA want the best health care for our members and their employees, and we want it at an affordable price. It is in our interest to strive for those goals. The state-certified health plans and state-established regional alliances have far less incentive to make the same

effort. Accordingly, we strongly support the Administration's proposal to allow us to form our own corporate alliance.

Corporate Alliance Disincentives

Our sense of our ability to exercise the corporate alliance option is, however, tempered by the severe disincentives included in the Administration's proposal. Unequal treatment between regional and corporate alliance status is evident in a variety of provisions. There are six specific areas that we would like to discuss to illustrate our point.

Employer-level caps: In general, under the Administration's proposal, employers are required to pay, on behalf of their employees, 80% of the average premium for health plans within their alliance. However, the Administration's proposal imposes a cap on the amount that employers participating in a regional alliance will be required to pay for health premiums on behalf of their employees. That amount is generally 7.9% of wages paid to employees, adjusted downwards to as low as 3.5% in the case of low-wage employers operating small businesses. Any excess premiums that would otherwise be due are paid for by the government. In sharp contrast, employers operating corporate alliances are subject to no cap whatsoever and receive no comparable government subsidy.

One percent of payroll assessment: The Administration's proposal directs all corporate alliance employers to pay a tax equal to 1% of payroll. By contrast, regional alliance employers are indirectly assessed an amount generally equal to 1.5% of health premiums. There is no apparent policy reason for this more burdensome treatment of corporate alliance employers. The policy underpinnings of this provision are even more uncertain since recent Administration modifications to the provision exempt multiemployer corporate alliances from the operation of the 1% of payroll requirement.

Family premium discounts: The Administration's proposal offers a federal subsidy for

payment of the employee share of health premiums to employees with family adjusted incomes of less than \$40,000. On the other hand, the proposal directs employers maintaining a corporate alliance for the benefit of its employees to pay for a similar subsidy, however in this case limited to employees earning less than \$15,000. We can discern no policy reason for this dissimilar treatment of low wage earners, and for the existence of a federal subsidy only in the case of employees participating in a regional alliance.

Reductions in cost sharing: With respect to individuals who are AFDC and SSI recipients or whose family adjusted income falls below the applicable poverty level, the Administration's proposal makes available reductions in the amount of deductibles, copayments, and coinsurance that the individuals would otherwise have to pay. These reductions are available only to individuals enrolled in regional alliances. This discriminatory treatment is compounded by the fact the subsidy is provided by the federal government. Similar reductions in cost sharing are not available to corporate alliance employees who would otherwise be eligible for the subsidy.

Involuntary termination of corporate alliance status: There are a number of situations in which an employer will permanently lose its corporate alliance status. For example, such status is lost permanently if it is found to be out of compliance with any requirement imposed by the proposal. Such status is also lost if certain cost containment targets are not attained. With respect to the same "offenses", regional alliances are subject to much less onerous penalties. We respectfully submit that less draconian penalties, like those applicable to regional alliances, should apply to corporate alliances.

In a similar vein, the rules should be clarified so that a rural electric or telephone cooperative that does not initially join a corporate alliance may do so at a later date. The use of permanent, irrevocable elections is inappropriate in the changing world of health care.

Corporate alliance status in single payer states: The Administration's proposal permits

states which opt to move to single payer status to elect whether to allow corporate alliances that otherwise comply with federal requirements to continue to exist. We believe that allowing the individual states such authority ignores the valuable role that employers currently play and should be able to play in providing cost effective, well-designed health benefits to their employees. As discussed above, employers are in the best position to evaluate and serve the health insurance needs of their employees.

The unequal and inappropriate treatment of corporate alliances with respect to the six areas discussed above should be remedied. Moreover, as a general matter, all disincentives with respect to corporate alliance status should be eliminated. Employers currently play and will continue to play an important role in the health care system and their operation should not be hindered by unequal treatment accorded corporate alliances.

Tax Status of Health Benefits Trust

Finally, we would like to raise one issue peculiar to rural electric and telephone cooperatives. Under the Administration's proposal, regional alliances would be tax-exempt. Under Internal Revenue Code section 501(c)(9), a health benefits trust established by a large employer or multiemployer plan could also be tax-exempt. We believe that the Administration's proposal should clarify that a health benefits trust established with respect to rural electric or telephone cooperatives could also be tax-exempt under section 501(c)(9). It would be severely unfair for a rural electric or telephone corporate alliance to be the alliance unable to use a tax-exempt trust to fulfill its duties.

Skimming Concern

The argument offered for certain unfavorable treatment of corporate alliances in the Administration's proposal is the so-called "skimming" concern. This concern is that an employer or group of employers will elect corporate alliance status only if such status will result in lower health care costs. Health care costs will generally be lower only if the employer's employees are, on the average, younger and healthier than individuals in the regional alliance

system. Because premium costs within a regional alliance are uniform, i.e., do not vary based on health risk, the employer with healthier employees would fare better on its own as a corporate alliance. Thus, the concern is that corporate alliances will "skim off" low-risk individuals and leave the high-risk individuals in the regional alliance. This skimming would, in turn, cause regional alliance premiums to be higher than they would otherwise be.

We recognize the legitimacy of this concern. However, we respectfully submit that the proposal's "penalties" on corporate alliances, such as the first four items described above under Corporate Alliance Disincentives, bear no relationship to this concern. No provision in the proposal determines whether any skimming has occurred. No provision imposes a penalty proportionate to any skimming. Instead, the proposal simply provides a long list of penalties on corporate alliances.

As discussed above, we believe strongly that there are good reasons to form a corporate alliance other than skimming, i.e., an employer's desire to design and administer its health plans in such a way as to be most responsive to the employer's employees. For example, in our case, the employees covered by NRECA's plan tend to be older and many encounter on-the-job hazards. In this light, it would be difficult to accuse NRECA of skimming.

Thus, we believe that in many cases a corporate alliance may not be skimming at all. In such cases, the proposal's array of penalties is simply inappropriate. In other cases, the effect of a corporate alliance election may be skimming, though often this result will be incidental to the employer's main objective, which is control over health plan design and administration.

In this light, we propose the following. The penalties on corporate alliances should be eliminated. Instead, there should be a single provision that would address the skimming problem directly. For example, there might be a mandatory reinsurance system in which all health plans participate. In this way, corporate alliance plans might share in the excessive risks absorbed by the regional alliances (and vice versa).

There may well be other more finely tuned means of addressing the skimming problem. We would support a full analysis of all such means. We oppose, however, the Administration's long list of unrelated penalties on corporate alliances. We reiterate our willingness to work with this committee in any way possible to modify the Administration's proposal, to create a level playing field that would permit employers acting as corporate alliances to design and administer health plans that are the best for their employees.

Mr. WAXMAN. Thank you, each of you, for your statement.

Dr. Karrh, I particularly appreciate the projections regarding corporate alliance enrollment that you attached to your statement. We have been looking for this information for sometime.

We seem to have a difference of opinion on this panel about the way the President's bill treats corporate alliances. All of you support the concept of allowing large employers and multi-employer plans to operate outside of the regional health alliances, but Dr. Karrh and Mr. Williams believe that the bill creates severe disincentives for employers to function as corporate alliances, including the 7.9 percent cap on employer contributions, the 1 percent payroll assessment, and the immediate revocation of corporate alliance status in the event of a violation of statutory requirements.

Ms. Mazo is continuing to look at the bill language, but she seems to think that the corporate alliance structure will work for most multi-employer plans.

Could you help us understand the differences in perspectives here? Is there something in the design of the bill that explains your differences?

Under the rules for corporate alliances, are large corporations and rural electrical cooperatives somehow treated differently than multi-employer plans?

Ms. Mazo?

Ms. MAZO. There is one important difference which has been mentioned. Multi-employer corporate alliances—by the way, one refinement we would like to make would be to have them called labor management alliances which they are established by labor management groups, and not corporate alliances. But aside from that are, that is cosmetic, would be exempted from the 1 percent assessment which, had that not been in the bill, would have made use of that mechanism impossible for multi-employer plans.

I think another aspect of the difference, very candidly, it is ironic to use it today in Washington, but we are looking at the glass as half full. We are pleased to see the opportunity to create the alliances and looking at refining some of the features.

We are concerned about State flexibility in some ways. We are concerned about a variety—we are concerned about the problem. We are also made up of small employers who would be giving up very significant subsidies if the bill is designed as it now stands. We are not as concerned about the 7.9 percent payroll cap, in part because we would not be working under the disadvantage of the 1 percent assessment.

Mr. WAXMAN. Mr. Williams?

Mr. WILLIAMS. I think we would agree with Dr. Karrh that any disincentive to having a corporate health alliance in terms of Federal subsidies that apply to the regional alliances that do not apply to the corporate health alliances are going to make it impossible for them to operate.

Certainly, in our situation where the participants in the corporate health alliance are going to be an amalgamation of a lot of small employers who would otherwise be eligible for some of the Federal subsidies I think would make it economically infeasible for us to operate one.

Mr. KARRH. I think, Mr. Chairman, that we really are not disagreeing with Ms. Mazo's position. I think the difference is that she is looking at a multi-employer plan, which we would encourage, but we are looking at a corporate alliance that has so many drop dead gates that you have to go through and so many other disincentives that I think large employers would have to really look at those incentives—those disincentives along with some of the incentives and decide whether or not it was really a viable option to even consider operating a corporate alliance.

Mr. WAXMAN. One of the points that you all seem to agree on is the issue of State discretion to adopt a single-payer approach. All of you oppose subjecting multistate employer plans or multi-employer plans to State by State controls.

Single-payer advocates, however, argue that unless States have the authority to include all employees and dependents and Medicare beneficiaries in their programs the single-payer approach cannot work.

Do any of you see any middle ground here? Is there some way to reconcile the interests of multistate employers and multi-employer plans with the desire of some States to establish a single payer health plan?

Mr. KARRH. I guess, Mr. Chairman, I don't see an ability to compromise that position if you have employees in a large number of States, any one of which could go single-payer. What we are trying to avoid as a multistate employer, and take my company as an example where we are operating in all 50 States, we have employees in all 50 States. If several of those States opted to go single-payer, we could find ourselves trying to administer health care plans across many different States, many different plans, and that would be administratively very difficult. It would be administratively very expensive, and it also would give disproportionate treatment of employees. It would make transferring employees between States and between sites very difficult for a corporation that is operating in a lot of different States.

Mr. WILLIAMS. I would agree totally with Dr. Karrh. I don't think there really is any middle ground.

Ms. MAZO. It could also end up disqualifying your corporate alliance if a particular State takes enough people out to throw you out of the size threshold.

Mr. WAXMAN. Mr. Williams, you testified against the provision in the President's plan for an assessment on corporate alliances equal to 1 percent of payroll. As I understand it, the purpose of this assessment is to help fund subsidies to academic health centers and graduate medical education costs.

You describe this as one of a number of penalties on corporate alliances, and you recommend instead requiring them to participate in a reinsurance program that applies to them and to plans offered by regional alliances.

My question is, under your alternative how do you propose we finance the teaching and research activities of academic health centers? And do you think this burden should be borne entirely by employers and workers participating in the regional alliances who under the bill face a 1.5 percent premium surcharge earmarked for this purpose?

Mr. WILLIAMS. No. We don't think it should be borne just by people participating in regional alliances. We would be perfectly in favor of contributing whatever is required of the regional health alliances.

We are just saying that the 1 percent on the corporate health alliance is going to represent significantly more of a contribution than the 1.5 percent of premium in the regional health alliance, and for particularly our membership, which would be an aggregation of small employers who would have to fund the 1 percent in order to participate in the regional—I mean in the corporate alliance, but would only have to fund the 1.5 percent of premium to participate in the regional alliance. It creates a definite financial disincentive for their participation.

Whatever you would decide would be a fair charge for one we would support for the other.

Mr. KARRH. Mr. Waxman, may I comment on that also, please?

Mr. WAXMAN. Sure.

Mr. KARRH. We have great difficulty with the 1 percent being put in prior to the 7.9 percent cap, because that gives us a hurdle of about a 6.9 percent inflation rate, or percent of payroll that we have to stay within in order for our plan to still qualify as a corporate plan. Then you have your other 1 percent on top of it.

We are in total agreement that we have a responsibility to bear our fair share of social responsibilities whatever that is. We just think that being tagged in the top of this 7.9 percent is inappropriate while being included in that.

Mr. WAXMAN. Thank you.

Mr. Greenwood?

Mr. GREENWOOD. Thank you, Mr. Chairman.

I tend to think that, contrary to the gentleman on the previous panel, that the 5,000 figure is too high for corporate alliances, and I only base that upon the fact that I have met with and spoken with companies smaller than that who self-insure and are very happy with it. They seem to be providing better health care at lower cost.

I asked Dr. Feder informally sometime ago why the 5,000 figure was chosen; why the administration seemed to want to discourage corporate alliances, and her response was, "Well, we just want as many people as possible in the regional alliance." It seems to me that these companies were there to serve the regional alliance rather than vice versa.

It seems to me that if I were an employer and seriously interested in forming a corporate alliance or self-insuring, I would have all of the motivation in the world to negotiate with a plan for the best coverage at the lowest price. I am paying 80 percent of it at least. I would have, I think, as an employer, very little confidence in the motivation of a State civil servant in my regional alliance to do that on my behalf.

My question, given all of that preface, is: do you think 5,000 is the right figure? Do you think that smaller companies could fare well as corporate alliances and isn't that motivation factor that I just mentioned, a real critical difference in terms of the motivation to negotiate?

Mr. KARRH. We think that definitely the 5,000 number is not the right number. We have suggested going down to 500 or perhaps even to 100 employees.

One of the previous speakers mentioned that below 5,000 there was not much cost savings opportunities for employers. We think in the past that may have been true, but there were not as many opportunities for different types of plan composures and organizations as there are now. We think that smaller alliances could actually now save money with some of the point-of-service and other types of plans and vehicles that are available to them to use.

We think also that to have a corporate plan where only 5,000 employees and above—and the numbers that I attach to my testimony show that those would be very, very small players in the total marketplace—competing with the regional alliances that, as Ms. Feder said this morning, would have something on the order of 73 percent of the market, and then a corporate alliance would be trying to compete against that large size.

Mr. WILLIAMS. We would definitely support lowering the number, and I think we have some numbers from our own membership that show currently and in the immediate past employers of less than 500 successfully self-insuring and saving money. We think another way to solve this problem would be to make participation in regional alliances voluntary.

Ms. MAZO. The issues that were raised this morning, however, about administrability and the extent of regulation that would become necessary if you have many different groups and people shifting between groups and requalifying and being re-enrolled and that sort of thing have to be looked at too. I think the question of sort of the specific gravity, of exactly how big the group needs to be outside the alliance is one question and the restructured health care scene envisioned by the President's program, the ability to successfully self-insure now might well not be the indicator of what would be able to be successfully running a cost effective program under the new regime. As Dr. Karrh has said, maybe that a thousand might become the limit of what is reasonable.

I don't know how much we would want to let trial and error or let employers of smaller size try and fail, and then kind of come limping into the regional alliance. That too might create other kinds of problems. I think it needs to be looked at very carefully and not just by saying, "Oh, smaller companies can do it well today, therefore why shouldn't they continue doing it?"

Mr. WILLIAMS. I would agree we have to be very careful about this. But a smaller company doesn't have to self-insure to do it. They could set up a plan some other way, with some other form of carrier.

Mr. GREENWOOD. It seems to me that when you talk about trial and error that this whole process in which you are engaged here is quite an experiment. And it would seem to me that having more rather than fewer individuals covered by corporate alliances and outside of the regional alliance would give us a better opportunity over time to judge the relative value and merits of the regional alliance than it would if we force such vast numbers into the regional alliance despite the fact that they might fare very well outside of the alliance.

Anybody want to comment?

Mr. WILLIAMS. I think we agree with that. We would also agree that we think that is an excellent experimental model to try in rural America where most of the proposals today, the Presidents and most of the ones we have seen don't have real good answers for how to make health care reform work in rural areas. They are all based on—most of the testimony we have listened to this morning has been based on concentrations of population.

We are dealing with—our membership is where we have—we don't have HMO's around the corner or PPO's on every block, and the extension of corporate health insurance to small and aggregations of small employers in rural America might well be a way to help them get a plan that is more competitive now.

Ms. MAZO. We, our membership, the Coordinating Committee wants both mechanisms to succeed. A large number of multi-employer plans, in fact, would like to move people into regional alliances, into broader, more socialized pools than just continuing to bear the cost, particularly in low wage industries.

We would also share some of the concern that was expressed by members of the previous panel about opening up greater opportunities to risk selection as you slice and dice the market once again.

Mr. KARRH. We think it is important that corporate alliances succeed, and we very strongly would like to be able to run our own corporate alliances. There are several reasons for this.

Our employees have come to expect this. Our employees that have been with our companies for any period of time have had their health care provided through the company. It is a very strong employee relations plus for us.

We also believe that we can do a better job in assuring quality and the cost management within the system than the large regional alliances can assure as far as the quality is concerned.

We think that where we are trying to transfer employees between locations we can provide comparable benefits throughout the entire system, so that as people go from one State to another there is not a disparate treatment between employee groups and it gives us equitable treatment between those groups.

And then we can use the experience rating of the employee population. We take all comers who come into the company. They are all—we don't screen anyone out. But when they come into employment of the company they get health insurance then irrespective of what their conditions may be. So we have experience rating, but it is a community using the corporate population as the community that is rated.

And then we think we can have better assurance of our year to year cost increases, better control of those, than we can have if we are paying into a regional alliance. But all we are asking is that the corporate alliances be made where they can be viable and not have so many disincentives that a large employer just would see no reason to go into the corporate alliance.

Mr. GREENWOOD. We talk a lot about wellness in this debate, and it seems to me that the corporate alliances are great motivators for all kinds of wellness programs for employees. I am not sure that is going to exist outside of the alliances. It seems to me that these regional alliances are to this health care plan what

O-rings are to the shuttle. Some people may not want to fly in it, at least for the first few flights.

Thank you, Mr. speaker.

Mr. KARRH. If I may respond to that, Mr. Chairman?

Mr. WAXMAN. Sure.

Mr. KARRH. Most of our members have pretty extensive prevention and wellness types of programs, life-style programs. We feel that we have incentives to do that, because we think it does help hold down our cost, as was pointed out this morning. It also helps with employee moral and it helps with productivity and it helps control absenteeism.

If we did not run corporate alliances and the regional alliances had prevention and wellness programs, they would not have the same incentive to try to address these other areas that we have mentioned, although they may still provide some absenteeism assistance and some productivity assistance.

The biggest problem would be, though, with the dependents, the family members, because our largest costs are the family members. We insure more non-employee lives than we ensure employee lives. Therefore, we are not worrying there about absenteeism and productivity, but we are worrying about health care costs, and there would not be the incentive for the regional alliance using a prevention-wellness program to hold down those health care costs. And so we may gain on the employee side from absenteeism and productivity gains, but we would certainly not gain on the family member side.

Mr. WAXMAN. Thank you very much.

Mr. Brown?

Mr. BROWN. Thank you, Mr. Chairman.

Dr. Karrh, if I could follow up on that. You are obviously larger than that, but if you were a smaller company what kinds of incentives would you need to—if you can perhaps extrapolate in some way, what kinds of incentives would you need to continue those sorts of wellness programs?

Obviously, you would still have, as we were talking about this morning, as you just mentioned, the productivity and moral issues supporting the continuation of such programs. But what would you need beyond that in terms of incentives on premiums? Or would you?

Mr. KARRH. It would be hard for me to speak for a smaller company, but I am not sure that there is that much difference between a smaller company and a company the size of our member companies, the size of DuPont, for example.

What we would like to—the incentive for us is in all three of those areas. That we hold down health care costs by using prevention and wellness and life-style programs. That we improve employee moral and productivity, and that we work on absenteeism. Employees rather than being ill and off the job, they are able to come to the job. I think those same incentives would hold across almost any size employer.

As far as what financial incentives, in our case at least, the health care costs that we think we can improve upon by prevention and wellness and the absenteeism and productivity costs are incentive enough for us to run those programs. If we didn't have those

incentives built into it, though, then we may have to decide that we did not want to put the additional moneys into running such programs.

Mr. BROWN. Let me pursue—did you want to add to that?

Mr. WILLIAMS. I would just say our trust is a group of about 850 rural electric cooperatives. We have had a wellness incentive program and reduced premiums of up to 5 percent for about 5 years now. We have well over two-thirds of the membership participating, and we think our experience demonstrates the effectiveness of this in reducing health care costs.

Mr. BROWN. Your reduction in premium was 5 percent?

Mr. WILLIAMS. Up to 5 percent, depending on what the individual employer did, what specific wellness—

Mr. BROWN. Can you tell me some of the things they did?

Mr. WILLIAMS. Well, smoking cessation. Overweight. We had a health screening model that the employees went through.

I don't have the whole list here in front of me. We have got a kit on it. I will be happy to send it to you.

Mr. BROWN. OK. I would like that. Thank you.

And it varied depending on what they were doing, the location, all of that?

Mr. WILLIAMS. Exactly. You could get as much as a 3 or 4 percent annual reduction or as much as a one time 5 percent reduction depending on what you did.

Mr. BROWN. Let me ask—I was a little confused on your statements in response to Mr. Greenwood's question on the size of the corporate alliances and bringing that number down. I was going to ask that.

I was going to ask you what size you think is optimal. But you said something, Dr. Karrh, that confused me a little bit. That your belief, I think you said, or your studies show that the health alliances will be 70 percent of employees, corporate alliances will only be 30. Is that what you said?

Mr. KARRH. No. On the information that is attached to my testimony is a chart that is prepared by the Employee Benefits Research Institute that shows what the average State regional alliance size would be, and it is in percentage. It gives actually the population in the alliance and then it gives the percentage.

And, if you look at that, and Ms. Feder verified that this morning, that 73 percent average population in the United States would be in regional alliances, given the 5,000 population size and given the fact that Medicare is carved out. So then that leaves 30 percent between Medicare and between the corporate alliances.

Her statement was that 9 percent of the population would be in corporate alliances, by their data. We were giving the benefit of the doubt, and we said 17 percent.

Mr. BROWN. So, I guess your point was that the corporate alliances then won't have much ability to affect prices because of its lack of size, relative size?

Mr. KARRH. Because of its lack of relative size in proportion to the regional alliances, and therefore we think that there needs to be some more competition within the marketplace opposite the regional alliance.

Mr. BROWN. Understanding that, and that is maybe a call for competing regional alliances. But putting competing regional alliances aside, if we just drop the size from 5,000, say, to 1,000 necessary to join a corporate alliance, it seems to me that those corporate alliances then, while large in the aggregate, there would be so many small ones that they would have even less bargaining power vis-a-vis the help of the regional alliances, would they not?

Because they can't operate together, the corporate alliances. There are so many small ones of 1,200 and 1,800 and 3,000.

Mr. KARRH. They would not operate together but that would put more competition into the marketplace. Right now you would have the very, very large regional alliances the way it is set up, according to this 70 percent of the population would be in the regional alliance. Then you would have a very few corporate alliances operating in any one region. So therefore they would not have the bargaining power against the large regional alliances' bargaining power.

If you had more corporate alliances, even if they did have smaller employers in it, you would have more capability of having some competition in the marketplace trying to get that business.

Mr. BROWN. What would be—for all three of you, what would be the ideal number in the Clinton health plan for the size of a corporate alliance, for a minimum size?

Mr. KARRH. We have suggested 500.

Ms. MAZO. We think we can live generally with the 5000 person figure. But I think if it were dropped it probably shouldn't be dropped below 1,000.

Mr. WILLIAMS. If we are going to succeed as a corporate health alliance it is going to be just the rural electric cooperatives, so the 5,000 is fine from that perspective. Generally, we would like to see that number go as low as people are comfortable with. We would certainly be comfortable with 500 or less.

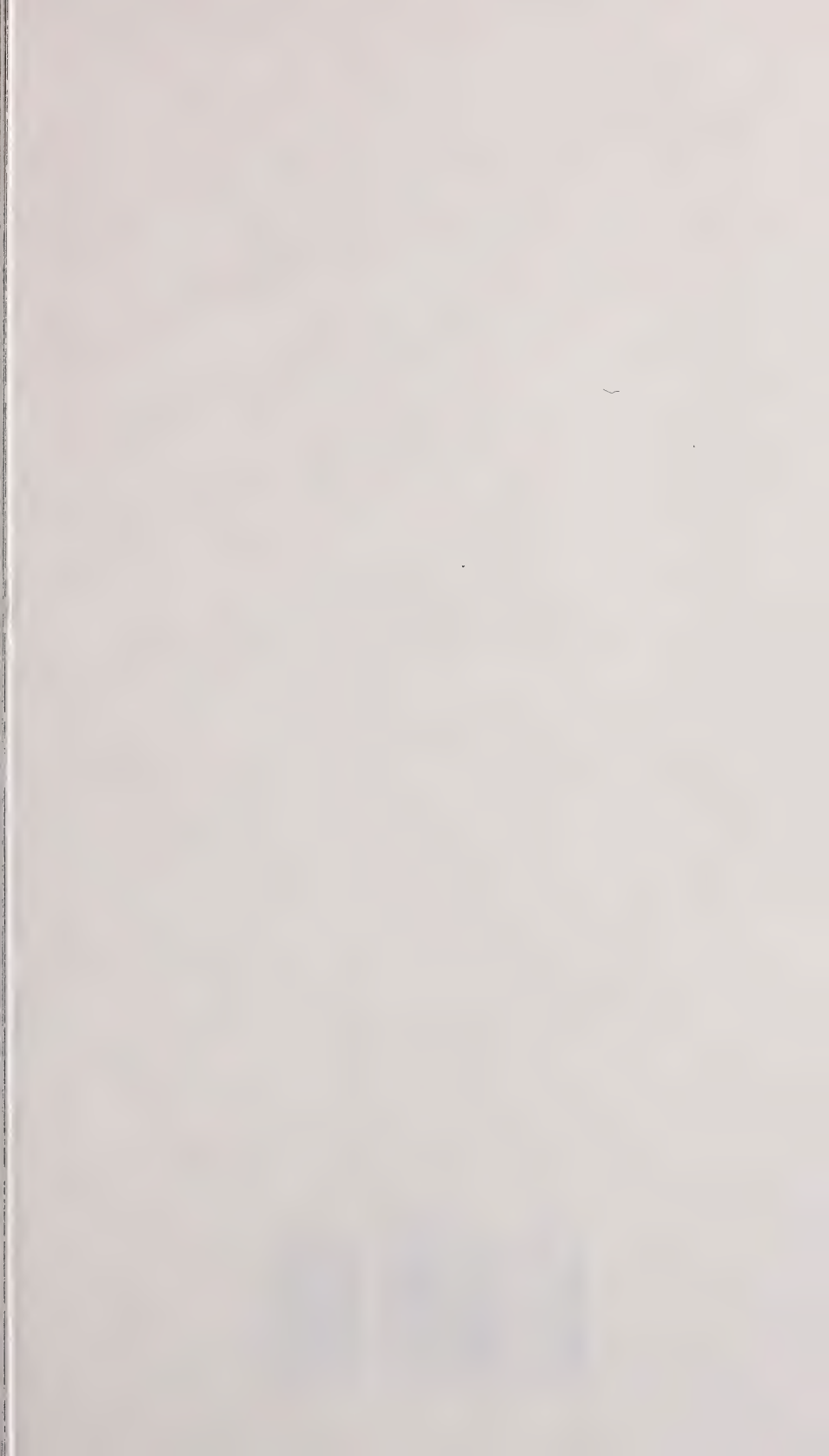
Mr. BROWN. Thank you. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you very much, Mr. Brown.

I thank you, each of you for your testimony. You have given us some very useful information, and we will continue to be in touch with you.

That concludes our hearing for today. We stand adjourned.

[Whereupon, at 3:37 p.m., the subcommittee was adjourned, to reconvene at the call of the Chair.]



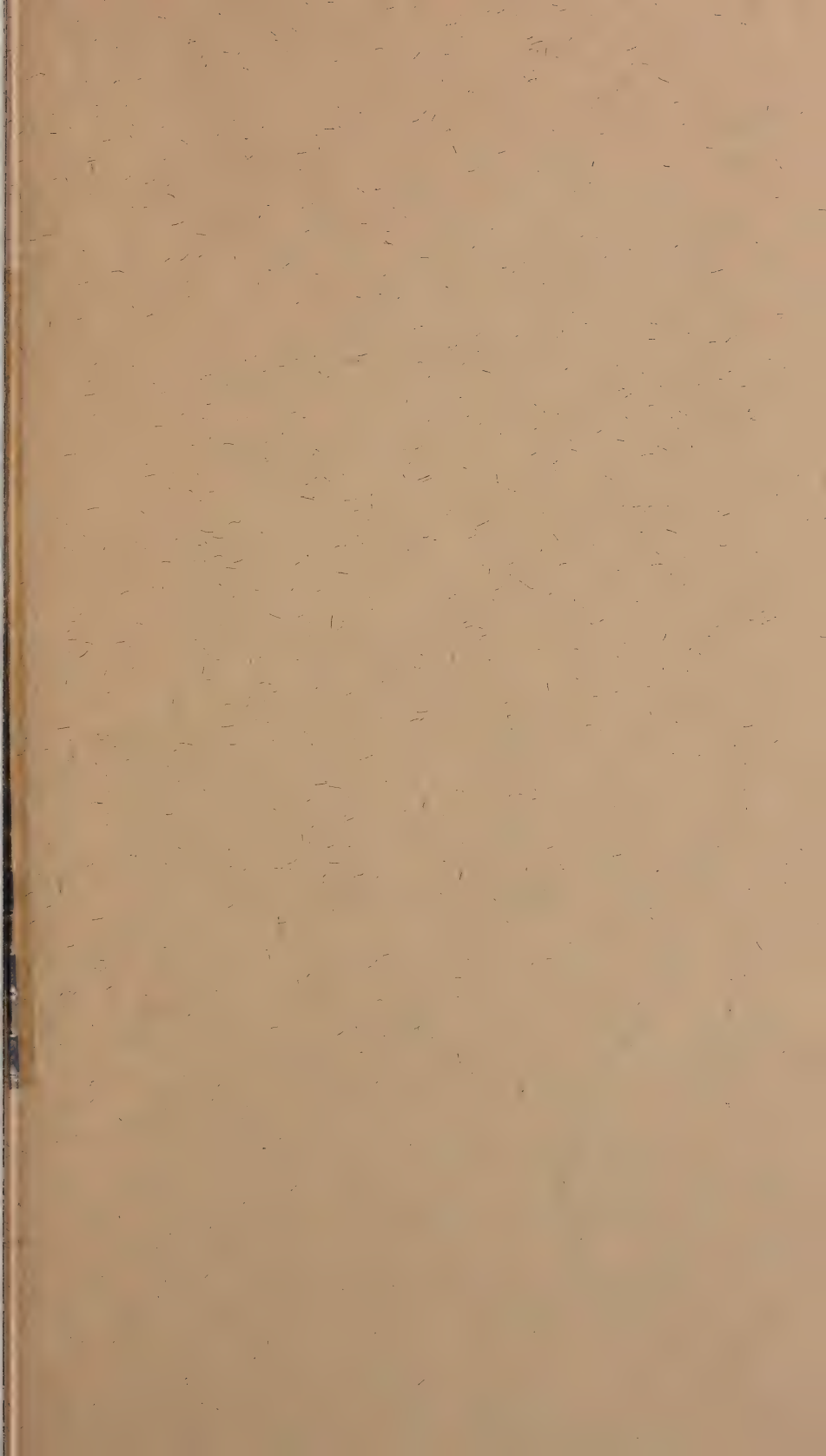
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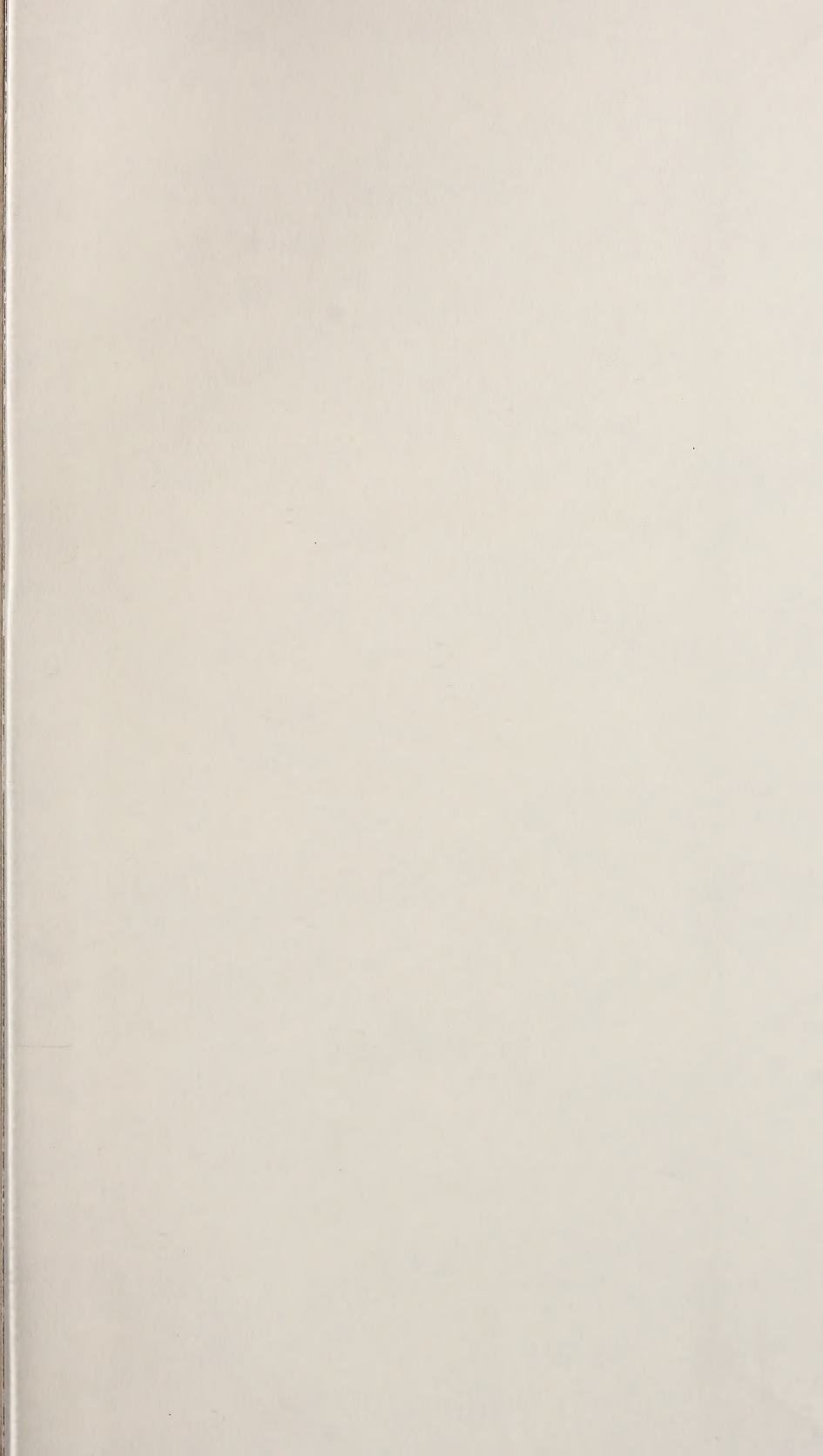
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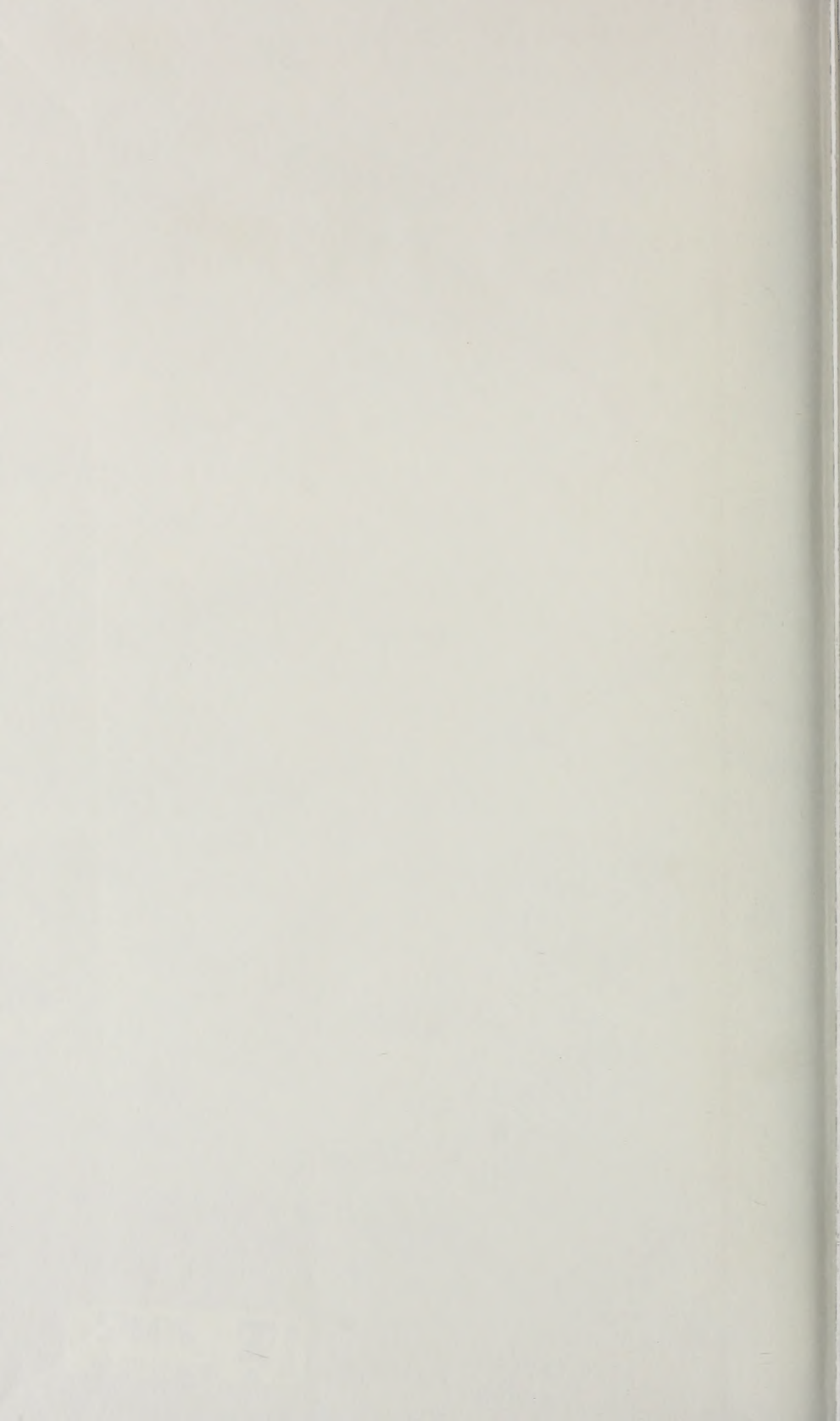
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